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HEALTH INSURANCE FOR THE AGED

PART B INTERMEDIARY MANUAL

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration

HIM-14 (7-66)

FOR OFFICIAL USE ONLY

6400 – Payment and Postpayment Procedures

6100 – Coverage and Limitations

6200 – Querying Master Files for Eligibility and Deductible Status

6300 – Bill Review

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FOREWORD

This manual is for official use only. It is intended to be used in the administration of the health insurance program by personnel of intermediary organizations. The contents of the manual should not be released. The intermediary may excerpt language concerning provisions of the law in communications with the public, but the manual should not be cited as a reference.

The manual is designed to be revisable to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

ARTHUR E. HESS, Director
Bureau of Health Insurance

PART B INTERMEDIARY MANUAL

PART 3 - CLAIMS PROCESS

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CHAPTER I

ELIGIBILITY FOR PAYMENTS

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Entitlement

6001. HOSPITAL INSURANCE BENEFITS ENTITLEMENT
An individual is automatically entitled to hospital insurance protection beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits whether or not he is actually receiving benefit payments. Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday. Example: If birth date is August 1, attainment date is July 31, and HIB entitlement date is July 1.)

A social security applicant who applies for monthly benefits after he has reached age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application. No benefits are payable for hospital or home health services rendered before July 1966, and no benefits are payable for extended care services rendered before January 1967.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

In the event that an individual's entitlement to monthly benefits ends because of death, no monthly benefits are payable for that month. However, his hospital insurance continues for the month of his death.

6001.1 Transitional Provision.--A special transitional provision in the law permits persons 65 years of age and over, who lack social security entitlement or railroad retirement qualification, to obtain hospital insurance protection upon filing application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee who

is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

To obtain coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance protection under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

6003. SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

A. Enrollment.--To obtain supplementary medical insurance coverage an individual must enroll in the plan and pay the required premium. He is eligible to enroll if he is entitled to hospital insurance benefits or is 65 years of age and otherwise meets the requirements for hospital insurance coverage under the transitional provision of the law. Active or retired Federal employees (or their spouses) are eligible to enroll whether or not covered under the Federal Employee's Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement, States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Persons entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. Enrollment Periods.--Enrollment is possible only during specified enrollment periods.

1. During the initial general enrollment period an opportunity to enroll was afforded to all persons age 65 and otherwise eligible before 3/1/66. This enrollment period ended 5/31/66. (An individual who was eligible to enroll during this period but failed to do so before 6/1/66, may, for good cause, enroll anytime before 10/1/66.)

2. For persons who first become eligible on or after 3/1/66, the initial enrollment period is of 7 months' duration. It begins

3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.

3. General enrollment periods occur October 1 through December 31 of each odd-numbered year beginning with 1967. These afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated.

4. States which desire to enroll eligible individuals receiving public assistance must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for supplementary medical insurance within the 3-year period after the close of his initial enrollment period is precluded from enrolling in the supplementary medical insurance plan.

An individual whose enrollment has terminated may reenroll only once and this must occur in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

6003.1 Premiums.--Initially, the premium is $3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount if medical costs rise. No increase in the premium is permitted before 1968, and increases thereafter can be made not more often than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls later than the first enrollment period open to him, or who reenrolls after his initial enrollment was terminated, are increased by 10 percent for each full 12 months he could have been but was not enrolled. A grace period has been provided for payment of premiums. This period extends for 2 months after the month in which the premium is due.

Social security and railroad retirement beneficiaries, and civil service annuitants (except those enrolled by the State as public assistance recipients) who elect to enroll under this plan will have the premium withheld from their monthly checks. The State pays the premium for the public assistance recipients it enrolls

including those who are social security or railroad retirement beneficiaries or civil service annuitants. Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, State or local government organizations, employers, unions or other organizations may desire to pay premiums for their members who would otherwise be paying their premiums by direct remittance. If the organization's enrollee group includes at least 100 members, a single bill for the group may be rendered monthly or quarterly at the election of the organization provided each member of the group has authorized this method of payment.

6003.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period--coverage begins 7/1/66. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolls between June 1, 1966, and September 30, 1966, will have coverage beginning the 1st day of the 6th month after the month in which he enrolls.

B. Enrollment during the individual's initial enrollment period--coverage begins:

1. 1st day of the month in which the individual becomes 65, if he enrolls before the month that he becomes 65.

2. 1st day of the month following the month that he becomes 65, if he enrolls in the month that he becomes 65.

3. 1st day of the 2nd month after the month of enrollment, if he enrolls in the month after he became 65.

4. 1st day of the 3rd month after the month of enrollment, if he enrolls more than one month after the month in which he became 65. (However, individuals who become age 65 in March 1966, and enroll in May 1966, will have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods--coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients--coverage begins on the latest of the following, but not later than January 1, 1968:

1. July 1, 1966;

2. 1st day of the 3rd month after the month of the agreement with the State;

3. 1st day of the first month in which the individual is both eligible and a member of the group;

4. the date specified in the agreement.

6003.3 Coverage Ends

A. An individual whose medical insurance premiums are being deducted may notify the Administration in writing, during a general enrollment period that he no longer wishes to participate in the supplementary medical insurance plan. In this case his coverage period is terminated effective with the close of the year in which his notice is submitted to the Administration.

B. Enrollment under the supplementary medical insurance plan is terminated because of nonpayment of premiums. Termination of the coverage period is effective as of the end of the grace period (see C. above) provided for payment of his premiums.

C. In the case of an individual enrolled under a Federal-State agreement, his coverage period ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments of a kind specified in the agreement; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.

3. A social security or railroad retirement beneficiary who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption if he is a social security or railroad retirement beneficiary or makes other arrangements for continued payment of premiums.

D. An individual will have coverage through the month in which he dies.

Filing the Request for Payment

6010. FORM SSA-1490 (REQUEST FOR PAYMENT)
A written request for payment will normally be made on a Form SSA-1490 or SSA-1490A. (The two forms are identical except the SSA-1490A has a snap-out carbon copy. See Chapter IV for an exhibit of the form.)

Form SSA-1490 is a two-part form which provides for payment to be made in either of two ways:

A. The patient can send in his receipted bills and claim reimbursement for himself; or

B. The patient can make an assignment of an unpaid bill to the physician or supplier of medical services if they mutually agree to this method of payment and agree to consider the reasonable charge as the full charge for the service.

An initial copy of the request Form SSA-1490 will be distributed to Part B enrollees, with the informational booklet, "Your Medicare Handbook." The intermediary will send a blank Form SSA-1490 to the insured after each nonassignment claim is processed. The Request for Payment form will also be stocked in social security district offices. The intermediary will stock physicians' offices to the extent possible. The intermediary may print his name and address on the form.

6012. CLINIC USE OF FORM SSA-1490
Clinics, independent of hospitals, which have agreements with physicians to bill on their behalf should use Form SSA-1490. The name of each physician who rendered services to the beneficiary (or of another in his behalf such as the physician director of the clinic), the description of the services rendered, and the charges should be shown on the form. The form should be signed by the clinic on behalf of the physician, and payment can then be made to the clinic for unpaid bills or partly paid bills. The physician may bill the patient or the carrier directly if he wishes, instead of following the clinic billing procedure.

In its initial dealings with the clinic, the intermediary should verify that the clinic has on file written authorization to receive payment on behalf of certain named physicians. A one-time execution of this authorization is all that is necessary by each physician. The authorization should be retained in the clinic's files. The form of the authorization should be similar to that required where a provider of services bills for patient services by physicians. (See § 6014.1 for sample authorization that may be used in these cases.)

The clinic is also required to submit to the carrier a statement that it will not submit bills for physicians for whom it does not have authorization on file.

6014. FORM SSA-1554, PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

The form SSA-1554 (see Chapter IV for an exhibit of the form) is used by providers who have agreements with physicians for the provider to bill for the physicians' services. (Upon arrangement with the intermediary, billing may be in the name of a department head.) The physician may be provider-based, i.e., hospital or extended care facility, or one who periodically renders services in the provider's institution. The physician may be salaried, receiving a percentage fee, or under set fee charge basis. (The Form SSA-1490 will be used in claims for such physicians' services rendered in connection with home health agency services.)

When the provider bills for a physician, the Part B intermediary servicing the area in which the provider is located or the carrier otherwise servicing the claim, i.e., Railroad Retirement Board annuitants' carrier or welfare carrier, will review and make payment for Part B services, irrespective of the location of the physician's principal office.

6014.1 Physician's Authorization for Provider Billing.--Where provider billing for patient services by physicians is being made, an authorization by the physician is required. A one-time execution of this authorization is all that is necessary by each physician. The authorization will be retained in the provider's files. The signature of the provider representative on Item 14 of the Form SSA-1554 will serve as a request for payment on behalf of physicians and also is a certification that proper authorizations by the physicians are on file. The following is a sample of an authorization for use by providers to satisfy this requirement.

"I hereby authorize the (name of institution) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

6016. FILING THE REQUEST--PAID BILLS

For paid bills the intermediary will reimburse the patient upon the receipt of a Form SSA-1490 and a receipted bill. The physician or supplier must either complete the lower part of the form, or show on the receipted bill enough information about services furnished to enable the intermediary to make a payment determination. If services or supplies were not furnished by a physician, the name of the physician prescribing the services or supplies must be shown. Under this receipted bill procedure, the patient can be reimbursed only 80 percent of the reasonable charges over and above the $50 deductible, regardless of the actual charges.

6018. FILING THE REQUEST--ASSIGNMENTS

If the patient wishes payment to be assigned to the physician or supplier of services, the patient should complete Part I and check "Yes" in Item 4 of Form SSA-1490. The physician or supplier should complete Part II and check the box in Item 12 to show his acceptance of the assignment.

Itemized information relating to medical services or supplies can be furnished on enclosed bills or by completion of Item 7 by the person accepting the assignment.

A separate form must be used by each physician or supplier requesting payment under the assignment method. If this procedure is used, the physician must agree to accept the reasonable charge as his full charge. The intermediary will pay the physician or supplier 80 percent of the reasonable charge over and above the $50 deductible, and the physician can collect no more than the 20 percent balance and the deductible from the patient.

6020. EXECUTION OF REQUEST FOR PAYMENT ON BEHALF OF INCAPABLE PERSON IN SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFICIARY CASES

(These cases are identified by health insurance claim numbers whose suffixes do not include M, M1 or T.)

A. Where a patient who is a Social Security or Railroad Retirement beneficiary is unable to execute a request for payment himself (Form SSA-1490 or Form SSA-1554), the request may be made on his behalf by his representative payee, i.e., an individual selected by the Social Security Administration or the Railroad Retirement Board to receive benefits on behalf of an incapable individual. The representative payee would stand in the same position as the patient himself in

requesting payment for paid bills or assigning unpaid bills. The signature line of the request should be completed with the name of the patient followed by "By" and the representative's signature and address.

The intermediary may honor a request by someone other than the patient or his representative payee if the patient is in such physical or mental condition that he could not or should not be asked to transact business at the time. When the patient is in such a condition and the representative payee is not available to sign the request, the request may be signed by his legal guardian, relative or friend, or representative of an institution providing him care or support or of a governmental entity providing him assistance. The requestor other than the legal guardian should attach a statement to the Request for Payment explaining his relationship to the patient and the circumstances which make it impractical for the patient to sign. If such a statement is not submitted, the intermediary should obtain the explanation from the requestor.

NOTE: The fact that such a request may be honored does not mean that payment can be made. (For discussion of who can receive payment see § 6027.)

B. When the reply to the eligibility and deductible status query (see Chapter III on querying the master file for eligibility and deductible status) shows a representative payee for a social security beneficiary who is other than the person who signed the request for payment on behalf of the patient, the intermediary should prepare a copy of the explanation described in A above and transmit it to the district office servicing the intermediary under cover of a transmittal showing the patient's name and address, health insurance claim number, as well as the requestor's name and address. The covering transmittal to the district office should indicate that the material is being submitted for possible investigation of a representative payee issue. However, the claim may be processed to payment provided the conditions in A above are met.

When the patient is entitled to monthly social security or railroad retirement benefits and is unable to file a request for payment on his own behalf because of alleged incompetency or incapability which is not likely to improve quickly and he does not have a representative payee, request the social security district office serving the intermediary to investigate and develop a representative payee.

6022. EXECUTION OF REQUEST FOR PAYMENT ON BEHALF OF INCAPABLE PERSON IN NON-BENEFICIARY CASES

(These cases are identified by suffixes M, M1 or T on the Health Insurance Claim Number.)

The intermediary may honor a request for payment (whether by assignment or for paid bills) by someone other than the patient if the patient is in such physical or mental condition that he should not be asked to transact business at the time. When the patient is in such a condition, the request may be signed by his representative payee, legal guardian, relative or friend, or representative of an institution providing him care or support or of a governmental entity providing him assistance. The requestor other than a representative payee or legal representative, should attach a statement to the request for payment explaining his relationship to the patient and the circumstances which make it impractical for the patient to sign. If such a statement is not submitted, the intermediary should obtain the explanation from the requestor.

NOTE: The fact that such a request may be honored does not mean that payment can be made to the requestor. (For discussion of who can receive payment, see § 6027.)

6025. EXECUTION OF THE REQUEST--PATIENT DECEASED

After the death of a beneficiary, whether the request is for direct reimbursement or is an assignment, the Request for Payment must be executed by a legal representative of the deceased's estate, including any representative under a small estates statute. (See § 6418 for disposition of underpayments in death cases.)

6027. WHO MAY BE PAID BENEFITS

A. Assignment Situations.--Where a request for payment has been properly executed (see § 6018), payment may be made to the physician or supplier accepting the assignment.

B. Non-Assignment Situations.--When a request for payment has been properly executed (see § 6016), payment may be made to the beneficiary directly in non-assignment cases where:

1. A representative payee is not shown on the query reply;

2. There is otherwise no evidence that the individual is incompetent or incapable; or

3. He is temporarily incapable, but his condition does not appear likely to continue indefinitely.

Where a representative payee is shown on the query reply payment will be made to such individual. Where a representative payee is not shown on the query reply and payment may not be made to the beneficiary

directly because of incapability which appears likely to continue indefinitely, request the Social Security Administration district office to develop for such a payee before payment is made. However, if the individual executing the request for payment identifies himself as a guardian, committee or other legally appointed representative, payment may be made to him. In such cases, advise the Social Security Administration district office that the patient appears to be incompetent or incapable of handling his own funds, and submit the name and address of the legal representative who has filed on the enrollee's behalf.

6027.1 Addressing Checks in Payee Cases.--Where a representative payee is shown on the query reply, the check to be made payable to such individual would be made out using the designation indicated on the query reply. This includes, but is not restricted to the following:

(1) (Payee's Name) for (Enrollee's Name)

(2) (Payee's Name) guardian of (Enrollee's Name)

(3) (Payee's Name) committee of (Enrollee's Name)

(4) (Payee's Name) conservator of (Enrollee's Name)

Where a legal representative not shown on the query reply has filed on behalf of the enrollee, the check addressed to the legal representative should include his title.

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6400 – Payment and Postpayment Procedures

6100 – Coverage and Limitations

6200 – Querying Master Files for Eligibility and Deductible Status

6300 – Bill Review

CHAPTER II

COVERAGE AND LIMITATIONS

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Incurred Expenses

6100. INCURRED EXPENSES
The supplementary medical insurance plan includes coverage for expenses incurred in connection with:

1. Medical and other health services including physician services and certain other services and supplies incident to a physician's services including outpatient hospital services.

2. Home health services for up to 100 visits during a calendar year.

3. Outpatient hospital diagnostic service deductibles imposed under the hospital insurance plan in connection with diagnostic studies furnished during the calendar year. Reimbursement of these expenses under medical insurance will be made by the hospital insurance intermediary.

Payment for physician services and additional medical and other health services rendered to individual beneficiaries is made on a reasonable charge basis. Payment will be made to the beneficiary, or to the physician or other party who renders services, depending on whether the receipted bill or the assignment procedure is used. Payment for covered medical insurance services rendered to beneficiaries by providers of services (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider and is based on the reasonable cost of the services furnished. Providers furnishing such medical and other health services will be reimbursed by the hospital insurance intermediary.

An organization which furnishes medical and other health services on a prepayment basis may elect to be paid on the basis of reasonable costs in lieu of reasonable charges.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of a request for payment or physician certification. The exception to this rule is amounts paid by the individual toward outpatient hospital diagnostic deductibles which constitute incurred expenses under medical insurance.

Covered Medical and Other Health Services

6102. PHYSICIANS' SERVICES
Physicians' services mean the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, and consultation. The services must be rendered by the physician.

It is immaterial where the professional services of the physician are performed as long as they are provided within the United States. They may be performed in the course of a home, office, or institutional call. A patient's home is anywhere that he makes his residence, e.g., a home for the aged, a nursing home, a relative's home, and so forth. If a physician renders professional services at the scene of an accident, these services are included.

A consultation is reimbursable when it is a professional service furnished a patient by a second physician or consultant at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report.

A patient's personal physician may make a charge recognizable under Part B for his personal and identifiable direction to interns and residents who are participating in the care of his patient. However, such a charge will be recognized only if the attending physician has carried out his professional responsibility to his patient by confirming the diagnosis and determining that the treatment was necessary, specifying the nature of the treatment to be performed and assuring that any supervision needed by the interns and residents was furnished. Charges for major surgical procedures (as defined by JCAH) and other complex and dangerous procedures or situations will be recognized only if the physician supervised the procedure in person. A hospital may, upon the request of a hospital-based physician, do the billing and receive payment on behalf of the physician for his professional services rendered to outpatients.

6102.1 Definition of Physician.--Physician means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs this function. A doctor of dental surgery or dental medicine having State authorization to practice is also a "physician," but only with surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone. (These services must be such services

as may alternately be performed by a qualified physician or dentist, and exclude routine dental care.)

The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

In all States, the issuance by the State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, such local standards will be used in determining whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations will be covered.

NOTE: The term "physician" does not include a Christian Science practitioner, chiropodist or podiatrist, chiropractor, naturopath, optometrist, or other such practitioners.

6102.2 Doctors of Medicine and Osteopathy.--The requirement that a doctor of medicine must be legally authorized to practice medicine and surgery by the State in which he performs his services means a physician who is licensed to practice medicine and surgery.

A doctor of osteopathy, in order to qualify as a "physician," must be legally authorized to practice medicine and surgery by the State in which he performs his services. Some States limit the practice of osteopaths. In four States, for example, osteopaths are limited in their practice to the manipulation of bones and muscles, and there are various other types of limitations imposed in some of the remaining States on the practice of osteopathy.

6102.3 Dentists.--A dentist may qualify as a "physician" under the health insurance program if he is a doctor of dental surgery or dental medicine legally authorized to practice dentistry by the State in which he performs his services. However, because of the general exclusion of payment for dental services, payment for the services of dentists is limited to those surgical procedures which may be performed either by a qualified physician or dentist.

6102.4 Physicians in Federal Hospitals.--There are many physicians performing services in hospitals operated by the Federal Government--

military hospitals, Veterans Administration hospitals, and Public Health Service hospitals. Normally the services provided by a physician in a Federal hospital are not reimbursable except when the hospital provides services to the public generally as a community institution. Such a physician working in the scope of his Federal employment may be considered as coming within the statutory definition of "physician" even though he may not have a license to practice in the State in which he is employed.

6102.5 Provider-Based Physicians.--The charges of provider-based physicians (e.g., those on a salary) including radiologists, anesthesiologists, pathologists, physiatrists, and others for services directed to the medical care of the individual patient must be specially billed either by the physician or by the provider on his behalf. However billed, reimbursement is made on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. Thus, charges for physicians' services rendered individual beneficiaries are allocated to the medical insurance program and distinguished from the cost of provider services payable under either the hospital or medical insurance plan. (See Chapter IV for form and procedures for billing for services of provider-based physicians.)

Provider-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs and, as such, will be reflected in amounts payable to the provider for services rendered program beneficiaries.

In apportioning the cost component and the professional component, an option is available in billing for the services of pathologists and radiologists.

6102.6 Interns and Residents.--Services performed by interns and residents--including physicians employed by a provider and acting in the capacity of an intern or resident--are reimbursable to the provider on a reasonable cost basis by the Part A intermediary even though the intern or resident is also a licensed physician. Services of interns and residents which are covered under Part B, but are not reimbursable on a reasonable charge basis even though such persons are physicians legally authorized to practice, include:

A. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs;

B. The diagnostic medical and surgical services performed in hospital outpatient departments by interns and residents-in-training not under an approved teaching program;

C. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program;

D. The medical and surgical services performed for extended care facility and home health agency patients by interns and residents (whether or not under an approved program) which are not covered under Part A.

6103. SERVICES AND SUPPLIES
Services and supplies (including drugs and biologicals which cannot be self-administered) are those furnished incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills, and hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

"Incident to a physician's professional service" means that the services are administered as part of the physician's professional services in the course of diagnosis or treatment of an injury or illness. They need not be administered personally by a physician but may be administered by a nurse or other aide upon the order of a physician. The services of a nurse or other aide sent by the physician to a patient's home for the purpose of rendering the service would not be covered.

The services of a physical therapist on the staff of a physician other than a physiatrist or orthopedist are not covered as "incident to a physician's professional service." However, when a physical therapist is a member of a physiatrist's or orthopedist's personal staff, working closely with him in his private office, the services the physical therapist performs are covered as "services incident to a physician's professional service" in the same manner that the services of a nurse and laboratory technologist working in the physician's office are covered.

Supplies of kinds which are "commonly furnished in physicians' offices" are confined to situations where it is the usual practice of physicians in an area or in a particular field of practice to furnish such items. Such items or services are covered even if provided outside the physician's office, e.g., on a home visit.

6103.1 Drugs and Biologicals.--Drugs and biologicals are covered only if they are of the type that cannot be self-administered and are generally limited to those that are administered by injection. Thus, injections would be covered even if required on a continuing basis, such as those for pernicious anemia, arthritis, etc., provided they are administered by the physician or his nurse. However, if the injection is of the type which is commonly self-administered, such as insulin, the drug or biological is excluded unless administered to the patient in an emergency situation.

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

Vaccinations or inoculations are covered if they are directly related to treatment of an injury or direct exposure such as antirabies treatment, tetanus, antitoxin, or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. On the other hand, immunization (vaccinations or inoculations) against such diseases as smallpox, polio, diphtheria, etc., are not covered.

Within the above limitations "drugs and biologicals" mean those included or approved for inclusion in the latest official edition of the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in the New Drugs or Accepted Dental Remedies, except for any drugs or biologicals unfavorably evaluated in these publications. Combination drugs are also included in the definition of drugs if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion in any of the above drug compendia.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and in Accepted Dental Remedies will apply to those drugs and biologicals which have been unfavorably evaluated for all medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, but not all, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals will be considered "approved for inclusion" in any of the drug compendia named in the Act if approved under the established procedure by the professional organization responsible for revision of the compendium.

6104. DIAGNOSTIC X-RAY, LABORATORY AND OTHER DIAGNOSTIC TESTS
Diagnostic x-ray, laboratory and other diagnostic tests, including materials and the services of technicians are covered. Some examples of other diagnostic tests are basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, radioactive uptake, allergy and prothrombin time tests.

Also included in "other diagnostic tests" is diagnostic psychological testing performed by a qualified psychologist when referral for such testing is made by a physician. A qualified psychologist is an individual who holds a doctoral degree in psychology from an American Psychological Association approved program in clinical psychology or its adjudged equivalent or, if

he does not hold a doctoral degree, has attained recognition of competency through the American Board of Examinations for Professional Psychology, State certification or licensing, or through endorsement by his State psychological association.

6104.1 Independent Laboratory.--An independent laboratory is one which is independent both of the attending physician's office and of a hospital participating in the program as a provider of services. A laboratory operating under the direction of a physician who holds himself out to the general public or other physicians as being available primarily for the performance of diagnostic x-ray or other laboratory services for other physicians, and a laboratory which is part of a nonparticipating hospital, are considered to be independent laboratories. "Independent" laboratory does not include a laboratory which a physician(s) maintains for performing diagnostic tests in connection with his own practice, or an out-of-hospital laboratory operated by or under the supervision of a participating hospital or its organized medical staff.

Diagnostic x-ray, or anatomical or clinical pathology services furnished by an independent laboratory are covered under medical insurance only if the laboratory is licensed pursuant to State or applicable local law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories. Such a laboratory must also meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare. After the certification process has been substantially completed, the carrier will be furnished a list of independent laboratories which meet the "Conditions for Coverage of Services of Independent Laboratories."

6105. X-RAY, RADIUM, AND RADIOACTIVE ISOTOPE THERAPY
These services also include materials and services of technicians.

6106. SURGICAL DRESSINGS, AND SPLINTS, CASTS, AND OTHER DEVICES USED FOR REDUCTION OF FRACTURES AND DISLOCATIONS
Surgical dressings include therapeutic and protective covering for lesions either on the skin or opening to the skin; splints and casts, including dental splints.

6107. RENTAL OF DURABLE MEDICAL EQUIPMENT
Durable medical equipment is equipment which can stand repeated use. It includes, for example, such items as iron lungs, oxygen tents, hospital beds, wheelchairs, and other ambulation devices such as crutches and walkers. It must be for use in the patient's home or in a place used as his home, such as a home for the aged or a relative's home.

NOTE: Charges for repairs to durable medical equipment already owned by the patient are also covered.

6108. AMBULANCE SERVICE

An ambulance is a specially designed or equipped automobile or other vehicle operated by trained personnel for transporting the sick or injured. It must have customary patient care equipment such as a stretcher, clean linens, first-aid supplies, oxygen equipment, etc.; and it must also have such adequate safety equipment as required by State or local authorities. The ambulance must be operated by personnel specifically trained for ambulance service who have completed a standard and advanced Red Cross first-aid course, or have equivalent training.

Carriers must secure certifications from suppliers of ambulance services in their area indicating whether the ambulance services meet all of the above requirements, and an agreement to notify the carrier of any change in their operations which could affect the coverage of their ambulance services. The certifications should be kept on file by the carrier.

To constitute "ambulance service" transportation in such a vehicle is limited to situations where:

A. It is required by the beneficiary's condition, and

B. The patient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home (or place used as his home), or to an extended care facility, or to a hospital where he had formerly been treated if the hospital is within a reasonable distance, and

C. Such transportation is not merely for the convenience of the patient. (Transportation by ambulance to a hospital, extended care facility, or rehabilitation center to obtain home health services not available to the individual in his home is covered only if the conditions in A, B, and C are met.)

"Locality," as used in requirement B, means the service area in the geographic territory surrounding the institution from which individuals generally come or are expected to come for medical service. In most cases, this should also be the area in which the supplier of ambulance service normally operates.

6109. PROSTHETIC DEVICES

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) and replacements or repairs for such devices. The term "internal body organ" includes the lens of an eye and all or part of an ear or nose. Protheses replacing the lens of an eye would include postsurgical eyeglasses which are customarily used during convalescence from eye surgery, or prosthetic lenses required by the aphakic patient.

6110. LEG, ARM, BACK, AND NECK BRACES, TRUSSES, AND ARTIFICIAL LEGS, ARMS, AND EYES

These appliances are covered only when supplied on a physician's order. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar and dorsolumbar corsets and belts. Replacements are included if required because of a change in the patient's physical condition. Repairs to and adjustment of such appliances, where necessary, are also included even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

General Exclusions From Coverage

6120. GENERAL EXCLUSIONS

No payment can be made under either the hospital insurance or supplementary medical insurance programs for the following items and services:

6120.1 Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in his home unless it was a reasonable and necessary part of the patient's treatment. Likewise, such potential personal comfort items and services as massages and heat lamp treatments are not covered unless they contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body organ.

6120.2 Items and services for which there is no legal obligation to pay.--This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, allowable benefits for covered items and services would be paid by the program even though the same services were covered by a prepayment plan. Such a plan might be a health insurance policy. This may be of the type which pays money toward the cost of services or it may be a plan that organizes and maintains its own facilities and professional supporting staff.

Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations. In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations.

This exclusion, therefore, does not prohibit program payment for services rendered to:

A. Members of religious orders who are not charged because of a vow of poverty;

B. Indigents who are not charged because of their inability to pay;

C. The patient whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;

D. Certain residents of homes for the aged. Coverage of health services furnished to a resident of a home for the aged depends on the arrangements under which the services are provided.

1. The typical relationship between the proprietary or profit-making home and the residents is contractual. The home agrees to furnish or pay for certain services, including health services, in return for certain specified payments by the resident. Other services not specified in the agreement must be paid for by the resident. Thus, payment can be made under the health insurance program for services received by the resident of such a home since the individual or the home has a legal obligation to pay for or provide the services.

2. Nonprofit homes are generally operated by religious or fraternal organizations. While these homes are subsidized to a greater or lesser degree, the resident is ordinarily required to contribute to the cost of his maintenance and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets and/or income at the time of admission. Where this is the case, payment may be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything at all for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by an independent hospital to which a resident of the home is sent, or for home health services furnished by an independent agency, or for the services of a physician who is not an employee of the home.

3. Certain union homes accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. Homes for Members of Religious Orders.--Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for

this care. Although these services are furnished in a setting that would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members who have rendered lifelong services. Thus, payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

6120.3 Items and services which are paid for by a governmental entity other than under the Social Security Act or under a health benefits or insurance plan for employees of the governmental entity. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for items and services (otherwise covered) even though provided free, if

A. furnished in or by participating State or local Government-operated hospitals, including psychiatric and tuberculosis hospitals, where the hospital is a general or special hospital serving the general community;

B. paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because of the individual's medical indigence. These services need not be furnished in a hospital. Thus, payment may be made for items and services furnished by a Government-operated home for the aged to the indigent aged of the community. Such items and services would be covered whether supplied directly by the home or purchased by it from independent physicians and hospitals.

6120.4 Items and services which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under certain limited conditions and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals.) The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

6120.5 Items and services which are required as a result of war, or an act of war, occurring after the effective date of the patient's current coverage.

6120.6 Personal Comfort Items.--These are items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Charges for special items requested by the patient such as radio, television, telephone,

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and air conditioner, and beauty and barber services are excluded from coverage. Items such as heat lamp treatments and massages are covered only when ordered by a physician.

6120.7 Routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or related examinations, or immunizations. Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations solely for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to examinations performed in conjunction with an eye disease such as glaucoma or cataracts, or to post-surgical eyeglasses which are customarily used during convalescence from eye surgery, or to prosthetic lenses required by the aphakic patient. In the last situation, the prosthetic lens is a replacement for an internal body organ--the lens of the eye.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

6120.8 Orthopedic shoes or other supportive devices for the feet. The exclusion of orthopedic shoes does not apply to such shoes if they are integral parts of leg braces.

6120.9 Custodial Care.--The custodial care exclusion precludes payment for patient care which primarily requires protective services rather than definitive medical and skilled nursing care.

6120.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery.--Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

6120.11 Charges Imposed by Immediate Relatives of the Patient or Members of his Household.

A. Members of the patient's household means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage as well as domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

B. Immediate relative as used in this exclusion means spouse, father, mother, son, daughter, brother or sister--by blood, marriage or adoption. Where a business enterprise imposes the charge, a determination must be made as to whether the firm in fact represents an individual within these relationships. If an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient.

6120.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

6120.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made for items or services under a workmen's compensation law or plan of the United States or a State. Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§6420ff.)

6120.14 Items and services which the provider is obligated by a law of or because of a contract with the Federal Government to render at public expense.

6120.15 Items and services furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of § 3013, or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

Deductible, Coinsurance, Psychiatric Limitation

6140. DEDUCTIBLE

In each calendar year a deductible of $50 must be satisfied before payment may be made under the supplementary medical insurance plan. Bills count toward the deductible on the basis of incurred rather than paid expenses and are subject to reasonable charge determination. Noncovered expenses do not count toward the deductible. Expenses incurred in the last 3 months of the previous year, which were applied toward the medical insurance deductible for that year, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year. The date of service determines when expenses were incurred, but expenses will be allocated to the deductible in the order in which the bills for those expenses are received by the carrier. An adjustment must be made, however, when expenses incurred in the 4th quarter of one year are used to satisfy the deductible for the following year and it is subsequently determined that the patient had incurred covered expenses prior to the 4th quarter of the earlier year. Even though an individual is not eligible for the entire calendar year, i.e., his coverage begins after the first month of the year, he is still subject to the full $50 deductible.

The amount of outpatient hospital diagnostic services deductible incurred by an individual during the calendar year under the hospital plan is includable as an incurred expense under the medical plan. It may be used to help satisfy the medical plan deductible and, if that deductible is satisfied, it is reimbursable under medical insurance. Payment for this incurred expense is made through the hospital insurance intermediary.

6140.1 Group Practice Prepayment Plans.--A special rule is applied to calculate the deductible for members of group practice prepayment plans which elect to be reimbursed on a reasonable cost basis. Once a month the Social Security Administration will credit each plan member with a fixed portion of the premium toward the deductible for that year. If in any year a member uses only covered services furnished by the plan, the deductible will be fully covered. If during the year, an individual receives covered services which are not provided by the plan, credit toward the $50 deductible at that time will depend on the accumulated credits for the months of the year in which the individual has paid premiums to the plan and any other expenses incurred by the individual which count toward meeting the deductible.

6145. COINSURANCE
After the deductible has been satisfied, the program will pay 80 percent of the reasonable charges incurred during the balance of the calendar year. The remaining 20 percent is the responsibility of the patient.

6150. PSYCHIATRIC SERVICES LIMITATION--EXPENSES INCURRED FOR PHYSICIANS' SERVICES
Regardless of the actual expenses for physicians' services incurred for treatment for mental, psychoneurotic or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of $312.50 or 62.5 percent of the actual expenses. The computation of psychiatric expenses for deductible purposes is also subject to the 62.5 percent rule. Since $312.50 represents 62.5 percent of $500, any amount of noninpatient psychiatric service expense in excess of $500 would not be considered in computing incurred expenses subject to reimbursement. Since the program's share of covered incurred expenses (after the $50 deductible) is 80 percent of the charges, the maximum possible payment for services would be 80 percent of $312.50, or $250. This maximum could be reached only if the individual has had $50 of incurred expenses other than noninpatient psychiatric service expenses. Where the beneficiary does not have any incurred expenses other than the noninpatient psychiatric service expenses, the maximum possible payment by the program would be $210.

6152. PSYCHIATRIC SERVICES LIMITATION COMPUTATION
To compute the benefit:

1. Consider all psychiatric expenses incurred up to a maximum of $500, whether or not applied to the deductible.

2. Multiply by .625.

3. Subtract any unsatisfied deductible.

4. Multiply by .8

Example A: In 1967, patient A had psychiatric treatment while not an inpatient and incurred total expenses of $600. The benefit payable is computed as follows: $500 (maximum incurred expenses) X .625 = $312.50. Since no part of the deductible has been satisfied for the year, subtract $50, leaving $262.50. The benefit payable is $210 (80 percent of $262.50).

Example B: Assume total psychiatric expenses while not an inpatient to be $800. $25 of nonpsychiatric expenses had previously been incurred and applied toward the deductible. The benefit payable is computed as follows: $500 (maximum incurred expenses) X .625 = $312.50. Since $25 of the deductible has already been satisfied subtract $25, leaving $287.50. The benefit payable is $230 (80 percent of $287.50).

Example C: Assume total psychiatric expenses while not an inpatient to be $35. $28 of nonpsychiatric expenses had previously been incurred and applied toward the deductible. The computation is as follows: $35 X .625 = $21.88. Since $22 of the deductible remains unsatisfied, and only $21.88 may be applied to the $22, the deductible has not been met and no payment would be made.

Example D: A beneficiary is receiving psychiatric treatment during 1967. He visits the psychiatrist's office once a week and the charge for these visits is $25 per visit. His total bill for services through October 20 is $400. On that date he is hospitalized for an acute mental disturbance and continues to receive treatment through the end of the year. A Request for Payment form for $750 in Part B charges is submitted. There are no other Part B medical expenses during the year. The total bill for services while the beneficiary was not an inpatient is $400. Sixty-two and one-half percent of this amount is $250. After subtraction of the deductible, 80 percent of the $200 balance can be paid. Since the remaining $350 in Part B charges were for services while the beneficiary was an inpatient, 80 percent of this amount may be paid as if they were regular medical (nonpsychiatric) expenses.

6153. APPLICATION OF THE LIMITATION

The term, "mental, psychoneurotic, and personality disorders," is defined as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual-Mental Disorders. The limitation applies only to expenses incurred for physicians' services rendered in connection with one of these psychiatric conditions (with no distinction being made between the services of psychiatrists and nonpsychiatrist physicians), and any items or supplies furnished by the physician in his own office. Services furnished by other health personnel including home health services and outpatient hospital services would not be subject to the special psychiatric limitation even

though the services are in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders."

The Act specifies that the limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation is applicable to services furnished by physicians in outpatient departments in a physician's office, the patient's home, and extended care facility, and so forth. The term, "hospital," in this context means a hospital which is primarily engaged in providing by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

6154. DETERMINING WHEN THE LIMITATION APPLIES

Where the physicians' services rendered are both for a psychiatric condition as defined in § 6153 and one or more nonpsychiatric conditions, it will be necessary for the carrier to separate the charges for the psychiatric aspects of treatment from the charges for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric and nonpsychiatric components are not readily distinguishable, all of the charges will be allocated to the primary diagnosis.

6154.1 Diagnosis Clearly Meets the Definition.--If in the carrier's judgment the primary diagnosis reported by the physician for a particular service is the same as, or equivalent to, a condition described in the APA's Diagnostic and Statistical Manual - Mental Disorders, the charge for the service will be subject to the benefit limitation for the "treatment of mental, psychoneurotic, and personality disorders."

6154.2 Diagnosis Does Not Clearly Meet the Definition.--Where it is not clear whether the primary diagnosis reported by the physician meets the definition of "mental, psychoneurotic, and personality disorders," or if no physician's diagnosis is given, e.g., where a receipted bill is submitted, it may be necessary to contact the physician to clarify the diagnosis. In deciding whether it is necessary to contact the physician in a given case, the intermediary will give consideration to such factors as the physician's specialty, the services rendered, the diagnosis, and the individual's previous utilization history.

A. Evidence Indicates Substantial Likelihood that Primary Diagnosis Meets Definition.--If, based on an evaluation of the above factors and any other pertinent information on file, the

intermediary feels there is a substantial likelihood that the individual has a condition which meets the definition of "mental, psychoneurotic, and personality disorders," the intermediary will contact the physician to ascertain whether this is actually the case.

B. Evidence Does Not Indicate a Substantial Likelihood That Primary Diagnosis Meets the Definition.--If the intermediary feels that the available information does not provide a fairly strong indication that the individual was treated for a condition which meets the definition, a presumption will be made that the physician's services were not for the treatment of a mental, psychoneurotic or personality disorder, and, therefore, are not subject to the psychiatric limitation. This would be the case where no diagnosis is given by the physician, and the patient's description of his condition does not suggest the fairly strong likelihood of a psychiatric diagnosis, and there is not other available information suggesting the likelihood of a psychiatric diagnosis.

6400 – Payment and Postpayment Procedures

6500 – Reports and Statistics

6200 – Querying Master Files for Eligibility and Deductible Status

6300 – Bill Review

CHAPTER III

QUERYING MASTER FILES FOR ELIGIBILITY AND DEDUCTIBLE STATUS

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QUERYING MASTER FILES FOR ELIGIBILITY AND DEDUCTIBLE STATUS

6200. GENERAL INFORMATION ABOUT COMMUNICATIONS BETWEEN CARRIERS AND SSA

SSA has established a magnetic tape record for each individual enrolled for health insurance. The Part B carriers will communicate with these tape records via wire transmissions, direct mailing of magnetic tape, or other available transmissions.

The major flow of transmissions will concern Part B queries and replies. SSA daily updates its records of deductible amounts, and incurred expenses for noninpatient psychiatric care (see §§6150ff.), reported in queries from intermediaries.

SSA sometimes receives queries about an individual from different intermediaries and is in a position to combine data from all sources to keep a current record for each individual. Only SSA, therefore, will determine when the deductible is met, and when the limit of $500 on computing incurred expenses for noninpatient psychiatric care has been reached for a year. For these reasons, the intermediary must query SSA for each claim until SSA notifies it that the deductible has been met. In the case of noninpatient psychiatric care, he must query SSA every time before making a payment until the dollar limit has been reached.

The Part A intermediary makes payment for the Part A outpatient hospital diagnostic deductible, which is an incurred expense under Part B, and for Part B outpatient hospital services and Part B home health services. The Part A intermediary is responsible for reporting to SSA the amounts to be credited toward the deductible or to be reimbursed under Part B.

6204. IDENTIFYING THE INDIVIDUAL'S HEALTH INSURANCE RECORD

When an individual becomes entitled to health insurance benefits, he receives a health insurance card with his name, sex, health insurance claim number, and the effective dates of entitlement to hospital insurance and/or medical insurance. The individual or his physician or other supplier must show the health insurance claim number on the Request for Payment, Form SSA-1490, and also on all other bills and documents that are sent to the intermediary. SSA records are maintained by the individual's health insurance claim number and it is essential that the intermediary use it in all communications with SSA.

The Social Security Administration maintains the tape records for individuals enrolled in the health insurance program. However, both SSA and the Railroad Retirement Board issue health insurance

cards. Most health insurance claim numbers are social security numbers with letter suffixes. The claim number may also be a Railroad Retirement Board number or social security number with letter prefixes.

6204.1 Health Insurance Claim Numbers Assigned by SSA.--The social security number always consists of 9 digits divided into 3 parts and separated by hyphens: 000-00-0000. The first 3 digits are referred to as the area, the second 2 digits as the group, and the last 4 as the serial number. The area numbers range from 001 through 587 and from 700 through 728. Any combination of 2 digits, except "00," make up the group number. The last 4 digits of the social security number, the serial portion, run from 0001 through 9999, and are repeated after each group.

The potentially valid SSA health insurance claim numbers are:

a. SSA Claim Numbers

000-00-0000-A
000-00-0000-B, B1, B2, B3, B4, B5, B6, B9
000-00-0000-C1, C2, C3, C4, C5 (see note)
000-00-0000-D, D1, D2, D3, D4, D5, D6, D7
000-00-0000-E, E1, E2, E3
000-00-0000-F1, F2, F3, F4, F5, F6, F7, F8
000-00-0000-HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9
000-00-0000-HC1, HC2, HC3, HC4, HC5 (see note)

NOTE: Subscripts higher than "5" are possible but are not likely to occur; there is no limit.

b. Special SSA Health Insurance Only Claim Numbers.--Some individuals who are not entitled to social security old-age, survivors, or disability insurance benefits, or qualified for railroad retirement, are entitled to health insurance benefits.

They use social security numbers with these suffixes:

000-00-0000-T
000-00-0000-M, M1

The suffix letter T indicates the individual is entitled to hospital, or hospital and medical, insurance. Suffix letters M and M1 indicate the individual is entitled to medical insurance benefits, but not to hospital insurance benefits.

6204.2 Health Insurance Claim Numbers Assigned by the Railroad Retirement Board.--The RRB began using the social security number in their numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers; these were assigned in numerical sequence, and have no special characteristics. However, both those 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes.

a. 6-digit Numbers.--The highest number assigned is known and is different for each group of prefixes as follows:

Prefixes	Numbers Assigned
A, MA, WA, WCA, PA, JA	000001 - 991273
WD, WCD, PD	000001 - 415935
H, MH, WH, WCH, PH	000001 - 049159

b. All-Inclusive List of Potentially Valid RRB Health Insurance Claim Numbers.

A-000000, or
A-000-00-0000

MA-000000, or
MA-000-00-0000

WA-000000, or
WA-000-00-0000

WD-000000, or
WD-000-00-0000

WCA-000000, or
WCA-000-00-0000

WCD-000000, or
WCD-000-00-0000

PA-000000, or
PA-000-00-0000

PD-000000, or
PD-000-00-0000

H-000000

MH-000000

WH-000000

WCH-000000

PH-000000

JA-000000

6206. PROCEDURES WHEN THE HEALTH INSURANCE CLAIM NUMBER IS NOT AVAILABLE OR IS INCORRECT

The health insurance claim number may be inadvertently omitted from the request for payment or other papers sent to the intermediary, may be obviously incorrect, or may be rejected as incorrect in SSA's reply to the eligibility query. When one of these happens, the intermediary may be able to get the correct number from his file if the patient has previously sent in a request for payment. Otherwise, the intermediary should ask the beneficiary or his representative for the correct number. It is possible, if

the patient is unable to give his health insurance claim number, that he did not file for health insurance or that his application is still in process. Suggest that he get in touch with the social security district office. The intermediary may also contact the nearest social security district office and ask them for help in getting the health insurance claim number.

If the intermediary receives an inquiry about replacing a lost or destroyed health insurance card, he should inform the inquirer to get in touch with the social security district office serving his address for assistance in obtaining another one. District office addresses are generally listed in local telephone directories under "Social Security Administration."

6208. JURISDICTION OF REQUESTS FOR PAYMENT

Part B carriers selected to serve in the administration of the medical insurance program are either assigned to service a particular geographical area or particular enrollees, i.e., Railroad Retirement beneficiaries and welfare recipients. For those carriers servicing geographical areas, the jurisdiction of a request for payment will be governed by the physician's or supplier's billing office regardless of whether services or items were actually furnished at such offices or elsewhere. This will hold true whether the bill is assigned to the physician, or supplier, or the beneficiary uses the receipted bill method of reimbursement. The only exception to this rule is the situation where the hospital bills for a hospital-based physician (form SSA-1554). In this situation, the carrier servicing the hospital's area will have jurisdiction for the claim, except (1) if the enrollee is identified as a Railroad Retirement beneficiary in which case, Travelers Insurance Co. would properly have jurisdiction of the hospital-based physician's claim, and (2) if the enrollee is a welfare recipient whose claims are handled by a welfare administration carrier.

Carriers servicing geographical areas should screen requests for payment to identify requests for payment of:

A. Enrollees who are welfare recipients whose claims are handled by a State agency. These welfare carriers furnish SSA with a membership list including the health insurance claim numbers. SSA records are then coded to show that these beneficiaries deal with the welfare administration carrier. This information will be given on query replies, when appropriate.

B. Enrollees who are identified as RRB annuitants (beneficiaries) by a 6-or-9-digit health insurance claim number with one or more letter prefixes. These claims are handled by Travelers Insurance Co. However, where the beneficiary is also a welfare recipient

under A. above, the welfare administration carrier would have jurisdiction.

Any misdirected requests for payment should be properly routed to the appropriate carrier.

6210. PRELIMINARY PROCESSING ACTIONS BY CARRIERS
Upon receipt of a request for payment, the intermediary checks to determine whether he is the proper intermediary.

If the request for payment was misdirected, the intermediary re-routes it, after extracting the information he needs to advise the sender that it was misdirected and is being sent on to the proper servicing intermediary. If the claim has a railroad number, transfer it to the appropriate intermediary.

The intermediary may receive a request for payment with receipts from two or more physicians or suppliers. If one or more of the physicians or suppliers is located in an area serviced by another intermediary, the carrier who received the request for payment should make a facsimile of it. He then forwards one copy plus the appropriate receipts to the other intermediary with an explanation. He also processes his part of the bill promptly and notifies the patient that his out-of-area claim has been transferred to another intermediary.

6212. DEVELOPMENT BY SERVICING INTERMEDIARY
The servicing intermediary must decide whether the services are covered and the charges are reasonable.

6212.1 Coverage of Services.--If the services are obviously non-covered, the intermediary denies the claim. If there is insufficient information to determine whether the service is covered, the intermediary will have to obtain a more precise description. (The intermediary may also query SSA for assistance.)

6212.2 Reasonable Charges.--The intermediary establishes the reasonable charge, contacting the physician or supplier, if necessary, to learn the basis for the fees.

6212.3 Checking Intermediary Records for Deductible Status.--When the carrier ascertains that the services are covered and the charges are reasonable, he checks the intermediary file to find out if he has a reply to a previous query to SSA from which he can determine if the deductible has been met for the year involved.

A. Deductible Has Been Met.--If the carrier has a notice in file from SSA that establishes that the deductible has been met

in the current year, and he knows that the current request does not involve expenses for noninpatient psychiatric care, he can process the request for payment without querying SSA.

Exception 1: The above applies only within one calendar year. As SSA receives queries from a carrier, it earmarks its file to notify that carrier of certain events (see § 6230.4). However, SSA records are not set up to carry over the identification of these earmarked carriers from one year to another. Therefore, the intermediary must query SSA for deductible status in the new calendar year in the same manner as the prior year, i.e., until an SSA reply is received indicating that the current year's deductible has been met or that the psychiatric ceiling has been reached. This is true even when the intermediary has information in file that indicates all of the $50 deductible was met in the last quarter of the preceding year and can be carried over.

Exception 2: When processing a request for payment any time after September 30, for expenses incurred prior to October, the carrier must query SSA unless SSA has already indicated that the deductible was met based on expenses incurred before October 1.

B. Deductible Has Not Been Met (and/or Psychiatric Expense Involved).--If the intermediary does not have a notice that the deductible has been met, or if expenses for noninpatient psychiatric care are involved, he must send a query to SSA. (Usually the intermediary will use a query code of "I.")

6212.4 "First-In-First-Out."--The intermediary applies expenses listed in requests for payment toward the deductible in the same order that the requests for payment are received, regardless of the dates expenses were incurred. (If bills are received simultaneously, the deductible will be applied on the basis of the earlier incurred dates. If two or more requests for payment involving one beneficiary are received from different physicians on the same day with the same incurred date, the deductible may be prorated.) This "first-in-first-out" method of handling requests for payment is to facilitate the prompt handling of bills. However, where an expense incurred in the last quarter of a year is being applied toward the deductible, the intermediary will make reasonable development to determine whether there were earlier covered expenses in that year. Such development is necessary because of the possibility of delayed receipt of bills for pre-fourth quarter incurred expenses which would necessitate subsequent adjustments. (See also Exception 2 in § 6212.3.A.)

6212.5 Beneficiary Submits Requests for Payment for Small Bills Before Deductible Is Met.--Beneficiaries are encouraged to maintain their own records until the $50 deductible is met. However, if they do submit requests for payment, the intermediary, after determining the services are covered and the charges are reasonable, queries SSA. The intermediary continues to report such expenses until he receives a notice from SSA indicating that the deductible has been met, or will be met on the basis of the current claim.

6215. QUERYING SSA--GENERAL

A. Providing for Payment Records.--When processing a request for payment, the intermediary provides for the preparation of payment data records to be forwarded to SSA after the bill is processed (see chapter VI).

B. Reporting Expenses.

1. Avoiding Duplication.--Once an amount has been reported in a query do not report it again in a subsequent query. Carriers are asked to check requests for payment including dates of service and other entries carefully against those previously received pertaining to the same beneficiary, to avoid duplication. The intermediary's file should be set up to facilitate these checks and to avoid duplicate payments.

2. Carry-over Expenses.--Expenses incurred in the last three months of a calendar year which apply toward the deductible for that year, also apply toward the deductible for the following year. SSA maintains a record of this. Therefore, when querying SSA, the intermediary reports the "First Incurred Dates" and "Reasonable Charges" during the first nine months, and those during the last three months, in separate fields.

3. Limitation on Noninpatient Psychiatric Expenses.--Both the reasonable charges for noninpatient psychiatric care reported in carrier queries and the "reasonable psychiatric charges remaining" reported in SSA replies are the full amounts without application of the 62.5 percent rule. However, when the carrier receives the reply from SSA, he takes 62.5 percent of the "reasonable psychiatric charges remaining" reported by SSA or 62.5 percent of the reasonable charges on this bill, whichever is less. He then

subtracts any deductible outstanding and computes the 80 percent benefit. After it is evident from an SSA reply that the $500 limit has been reached, the carrier does not have to submit any more queries for psychiatric expense status for that calendar year.

C. Two Calendar Years Involved.--When the request for payment includes incurred dates that are not in the same calendar year, prepare separate queries.

D. Selecting Query Codes.--Various query codes are available to identify the type of data that the intermediary is transmitting to SSA. (See column "26" below.) For example, after SSA has notified the intermediary that the beneficiary's entitlement to Part B has terminated, the intermediary must still report amounts for services or supplies incurred prior to termination. He uses a query code of G.

To correct a money amount previously reported in a routine query coded I, the intermediary repeats the incorrect amount in a new query using a C query code. The C code also alerts SSA that a corrected amount follows. The intermediary then transmits the corrected amount in a query coded E. The C and E queries must be transmitted the same day or SSA will reject the query. If a follow-up is made, both D and F queries must also be sent the same day.

If the intermediary wants to cancel the entire previous query (I code) instead of correcting it, he so indicates in a new query using an A query code.

6220. MAGNETIC TAPE SYSTEMS QUERY RECORD LAYOUT

For magnetic tape query input header and trailer data, see exhibits 2 and 3. For the record layout follow the guides below and in exhibit 1. The "Numbered" column below refers to the numbers shown in the record layout, exhibit 1.

No. of Columns	Numbered	
12	1-12	HI Claim Number. (See § 6204 for an explanation of HI claim numbers.) The number is shown left-justified with unused columns blank.
11	13-23	Beneficiary Surname. It should be left-justified with unused columns blank. Do not show: Jr., Sr., etc. Show two-word surnames as one word.

No. of Columns	Numbered	
2	24-25	Beneficiary Initials. The beneficiary's first and middle initials follow the surname. Use a blank if there is no middle initial.
1	26	Query Code. This code identifies the type of query involved. The query codes are:

Query Code:

A Void Query. When a prior query is to be completely cancelled and not replaced, cancel it by retransmitting the same prior query data using an A query code.

C Credit Query. Use this code when sending a query to credit an amount given in a prior query. This removes the amount given in a previous I-coded query, and indicates that an E-coded query will follow with the corrected amount. (SSA must receive the C and E queries on the same day or it will send a reject reply using disposition code 47.)

E New Debit Query. Use this code to report a new debit after an amount previously reported in an I-coded query has been credited in a C query. SSA updates its deductible and noninpatient psychiatric expense totals on the basis of this type of query.

G Routine Claim Query--Termination Involved. Use this code to report amounts for services or supplies obtained during a period in which the individual was still entitled to Part B, after SSA has furnished the information that the beneficiary's entitlement to Part B payments has terminated for a reason other than death (disposition code 44). SSA updates its records on the basis of this type of query.

I Part B Deductible and/or Psychiatric Query. Use this query code to request status when a claim is pending. SSA updates its deductible and psychiatric care totals on the basis of this type of query.

K Part B Entitlement Status Query. Use the K query code to request status when no claim is pending. It is used when the intermediary needs information from SSA's

records to process correspondence, to assist in resolving questionable items prior to submitting a routine claim inquiry, etc. SSA does not update on the basis of this type of query. When a code K query is used, the year must be indicated in the January-September field as follows: ARS transmissions: In the SI field transmit the actual month or two zeros for the month, and the last two digits of the year. Magnetic tape transmissions: In the "First Incurred Date (January through September)" field, transmit the last digit of the year and the actual month or two zeros for the month. In both ARS and magnetic tape code K queries, the money fields may be omitted or zero-filled.

NOTE: Second requests may be made if no reply has been received after 7 days (not including Saturdays, Sundays, and legal Federal holidays). Queries should not be followed up routinely, since indiscriminate use of the followup codes will further delay replies or may cause a duplicate posting in SSA records if SSA inadvertently handles the query and followup as separate claims. To indicate that this is is a second request to a previously submitted query, use these query codes:

Use Query Code:	To Followup on Prior Query Codes:
B	A
D	C
F	E
H	G
J	I
K	K

No. of Columns	Numbered	
1	27	Sex. This is the sex of the beneficiary as obtained from the request for payment or other records in the intermediary's possession. Use "1" for male and "2" for female.
5	28-32	Intermediary Number. This is a number assigned to the intermediary by SSA.
10	33-42	Intermediary Control Number. The intermediary assigns this as his identification number for SSA to use in the reply.

NOTE: When the first expense being reported in this query was incurred in the last 3 months of the year, transmit zeros or blanks in columns 43 through 56 and report dates and charges in columns 57 through 70, as needed.

3 43-45 First Incurred Date (January through September). Fill in these columns when the first expense that is being reported in this query was incurred in the first 9 months of the year. When the query includes more than one incurred date, report the earliest date. Show the last digit of the year followed by two digits for the month. If the month is one digit, precede it with "0;" e.g., show "607" for July 1966.

Part B Reasonable Charges (January through September). Transmit the total amount of reasonable charges reported on the request for payment form, that were incurred during the first 9 months of the year. Show zeros in unused columns. Separate medical charges as follows:

No. of Columns - Numbered		
4 (for $) 2 (for ¢)	46-51	Reasonable Medical Charges for other than Psychiatric Care
3 (for $) 2 (for ¢)	52-56	Reasonable Charges for Noninpatient Psychiatric Care. (Report any inpatient psychiatric expense in the 46-51 field.)

NOTE: When all of the expenses being reported in this query were incurred in the January through September period and no expenses were incurred in the October through December period, columns 57 through 70 will be zeros or blanks.

3 57-59 First Carry-Over Incurred Date (October through December). Transmit the earliest date reported on the request for payment that falls in this quarter. Use one digit for the year followed by 2 digits for the month.

Carry-Over Part B Reasonable Charges (October through December). Transmit the total amount of reasonable charges reported on the request for payment form that were incurred during the

last quarter. Show zeros in unused columns. Separate medical charges as follows:

4 (for $) 2 (for ¢)	60-65	Reasonable Medical Charges for Other than Psychiatric Care.
3 (for $) 2 (for ¢)	66-70	Reasonable Charges for Noninpatient Psychiatric Care. (Report any inpatient psychiatric expense in the 60-65 field.)
	71-75	(80) The query record may be terminated by: (1) All record marks in positions 71-75, (2) Blanks in 71-74 with a record mark in 75, (3) Record marks in 71-80, or (4) Blanks in 71-79 with a record mark in 80.

6222. ADVANCED RECORD SYSTEM (ARS) QUERY FORMAT

For details of telecommunication procedures, intermediaries directly connected to the Advanced Record System should refer to Volume I of the SSA Telecommunications Operating Procedures (T.O.P.) Advanced Record System, and the related addenda, furnished under separate cover. Intermediaries directly connected to the Blue Cross Association's wire system should refer to Telecommunications System Principles of Operation, Tributary Station, issued by the BCA.

Transmit data to SSA as indicated below. Also see Exhibit 4, ARS Query Coding Sheet. The data following each field identification code must be left-justified and each field must be terminated by a period. The omission of a period will cause an edit error in two fields of the message and may cause an edit error in two messages. When the teletype operator discovers that she has made an error in a message, she must exactly follow the error correction procedures specified in the "T.O.P." mentioned above.

The HI claim number (CN field) and the beneficiary's name (CH field) must appear in every query. An error in the HI claim number will delay processing the query.

Field Identification Code	
II	Prefix Code. This indicates the type of traffic and the start of a new query. If the prefix code is shown incorrectly, it will result in two queries being combined. An "II" must be shown to identify each query.

The field identification codes below are followed by (F) when the field is fixed and by (V) when the field is variable.

Field Identification Code		No. of Characters	
IN	(F)	5	Intermediary Number. This is a 5-digit number that SSA has assigned to the intermediary.
IC	(V)	10	Intermediary Control Number. The intermediary may assign himself a control number, and show it here, for SSA to use in the reply. This field is variable in length up to a maximum of 10 positions. A control number of 365 is entered "IC365."
TQ	(F)	1	Type of Query. Query codes are used to indicate the type of data that the intermediary is transmitting to SSA. Intermediaries who have access to ARS use the same query codes as those used for magnetic tape transmissions (see § 6220).
CH	(V)	14	Claim Holder. In this field furnish the name and sex of the "claim holder," i.e., the beneficiary or potential beneficiary. Show up to 11 letters of the surname followed by a comma and 1 or 2 initials. If the surname is less than 11 letters, key a comma immediately after the last character of the surname. One or two initials are entered immediately following the comma. Do not show Jr., Sr., III, etc. Show two-word surnames as one word. Do not use hyphens, apostrophes, or other punctuation within the surname field. Immediately after the initial or initials, show a period. Right after the period, key a one-position sex code: "1" for male, "2" for female, and "3" for unknown.
CN	(V)	12	Claim Number. The HI claim number follows this code. (See § 6204 for an explanation of HI claim numbers.)

NOTE: When the SI code precedes a field, it must be followed by an RC and/or PC field (except when the query code is K). When all the expenses being reported in this query were incurred in the last quarter of the year, omit the SI, RC, and PC fields.

SI (F) 4 First Date Incurred (January through September). Use this field when the first expense being reported in this query was incurred during the first 9 months of the year. This refers to the expense for either medical care other than psychiatric, or for psychiatric care. When the request for payment includes more than one date, report the earliest date. Show month and year in that order. January is shown as "01," 1968 as "68," etc.

NOTE: It is imperative that the cents positions be included in all money fields of the query. But do not place a decimal point between the dollars and cents.

RC (V) 6 Part B Reasonable Charges for Medical Care Other Than Psychiatric (January through September). Show the reasonable charges for medical care other than psychiatric that are being reported in this query. These expenses must have been incurred during the first nine months of the year. This field has a maximum of six characters. Examples: For $150.00, transmit: RC15000. For $22.00, transmit: RC2200. If charges exceed $9999.99, transmit that amount.

PC (V) 5 Reasonable Charges for Noninpatient Psychiatric Care (January through September). Transmit the reasonable charges for noninpatient psychiatric care reported in the request for payment up to $500.00. Do not include expenses incurred in the last quarter of the year. This field has a maximum of five positions. Example: For $125.00, transmit: PC12500. For $25.75, transmit: PC2575. (Any inpatient psychiatric expenses covered by Part B are shown in the RC field.)

NOTE: When the CD code precedes a field it must be followed by a CC and/or CP field. When all the expenses being reported in this query were incurred prior to the last quarter, omit the CD, CC, and CP fields.

CD	(F)	4	First Date Incurred (October through December). Transmit the earliest date being reported in this query that falls in this part of the year. This refers to the earliest date that expenses were incurred for either medical care other than psychiatric or for psychiatric care. This field is 4 positions in length. Show two digits for the month and the last two digits of the year in that order.
CC	(V)	6	Part B Reasonable Charges for Medical Care Other Than Psychiatric (October through December). Transmit the total reasonable charges for medical care other than psychiatric that are being reported in this query. The field is a maximum of six positions. Examples: For $1,010.00, show: CC101000. For $20.00, transmit: CC2000. If charges exceed $9999.99, transmit that amount.
CP	(V)	5	Part B Reasonable Charges for Noninpatient Psychiatric Care (October through December). Transmit the total reasonable charges being reported in this query that were incurred during the last quarter of the year up to $500.00. This field has a maximum of five positions. Example: For $138.50, transmit: CP13850. (Any inpatient psychiatric expenses are shown in the "CC" field.)

6230. ACTIONS BY SSA

SSA maintains an up-to-date record of each beneficiary's status, using expenses reported in queries received from the intermediary to update the deductible amount on the SSA tape record. The record will include separate totals for psychiatric and nonpsychiatric expenses. SSA will also maintain the amount of any carry-over deductible.

6230.1 Furnishing Status.--Upon receipt of each new inquiry, SSA notifies the current inquirer of the amount of the deductible that still has not been satisfied. When the query reported expenses

for psychiatric care, SSA also furnishes the amount of additional reasonable charges for psychiatric care that can be considered without exceeding the $500 limit of incurred expenses. SSA's reply gives the status prior to receipt of the current inquiry and enables the intermediary to determine whether he can make a payment. EXCEPTIONS: Replies containing disposition codes "21" and "22" furnish status after adjustments have been made based on the current inquiry. (See query codes A, C, and E.)

6230.2 Deductible Status Is Not Furnished in Some Instances.--SSA will not furnish a deductible status in reply to an intermediary when:

a. The reported incurred date precedes the month of the beneficiary's entitlement to Part B, or

b. His entitlement to Part B has ended, or

c. When a welfare carrier has been designated and a different carrier is inquiring.

There is an exception to b. above. SSA will reply when the intermediary used a query code of "G" indicating that he is aware of the termination but is reporting expenses incurred prior to termination.

6230.3 Representative Payee Information.--A representative payee is a person responsible for handling a beneficiary's monthly cash benefits when the individual is unable to do so for himself because of mental or physical infirmities. (See chapter I for additional information about representative payees.) SSA tape records will maintain the name and address of the representative payee if one has been selected for the beneficiary, and furnish it in each reply.

6230.4 Automatic Notifications by SSA.--After SSA has received queries reporting amounts sufficient to satisfy the deductible, it will reply to subsequent queries by furnishing a "deductible remaining" of zeros. For the balance of the calendar year, SSA will automatically notify the carrier(s) that have submitted queries and received replies indicating the deductible is met if:

a. Part B entitlement has terminated for a reason other than death.

b. A representative payee has been selected, changed, or is no longer needed.

c. The individual's SSA account has been credited. For example, if the amount of the deductible has been adjusted or if the amounts previously applied to the $500 maximum for psychiatric care have been adjusted.

6233. DATA SHOWN IN SSA REPLIES TO INTERMEDIARIES
SSA uses form layouts to reply to intermediaries using magnetic tape oriented systems and also for intermediaries who have access to the ARS. The order in which information is to be furnished and the number of positions in the fields for each system are shown in §§ 6234 and 6235 below.

6234. MAGNETIC TAPE SYSTEMS REPLY RECORD LAYOUT
Follow the guides below and in exhibits 7 through 11. Exhibits 5 and 6 give the magnetic tape query output format header and trailer data. The "Numbered" column below refers to the numbers shown in the record layout, exhibits 7 through 11.

No. of Columns	Numbered	
1	1	Blank.
5	2-6	Intermediary Number. This is a number assigned to the intermediary by SSA.
12	7-18	Health Insurance Claim Number. (See § 6204 for an explanation of HI claim numbers.) This is always the same number that the intermediary included in the inquiry. It is left-justified; unused columns are blank. See disposition code 45 below for rejects and the field preceded by record code 3 for the correction.
2	19-20	Disposition Code. This code identifies the type of reply. A list of types of replies follows:

Disposition Code (Columns 19-20)	Condition
00	There will be a delay; SSA is investigating. Definitive reply will follow.
01	Approval. This is an unqualified reply containing data requested in the query.
02	Approval. Beneficiary's entitlement to Part B terminated by death.

Disposition Code (Columns 19-20)	Condition
21	Acknowledgment. Query code A (void credit) has been received and posted. This reply furnishes status after adjustment has been made based on the current query.
22	Acknowledgment. Query code C and E (adjustment credit) has been received and posted. This reply furnishes status after adjustment has been made based on the current query.
41	Rejected. Date of first expense is prior to entitlement date.
42	Rejected. Individual has never been entitled to Part B.
43	(Not used)
44	Rejected. Beneficiary's entitlement to Part B terminated for reasons other than death.
45	Rejected. Unable to identify beneficiary by the HI claim number given in the query. Recheck name and HI claim number. Contact beneficiary or SSA district office if necessary.
46	Rejected. Beneficiary is serviced by a special intermediary. (Welfare carrier).
47	Rejected. Query code C and E received without the counterpart. Resubmit entire adjustment, using C and E again, not the followup query codes.
81	Edit error. HI claim number. Resubmit query.
82	Edit error. Query code. Resubmit query.
83	Edit error. Name. Resubmit query.
84	Edit error. First incurred date. Resubmit query.
85	Edit error. Reasonable medical charges. Resubmit query.

Disposition Code (Columns 19-20)	Condition
86	Edit error. Reasonable psychiatric charges. Resubmit query.
87	Edit error. Carry-over data. Resubmit query.

Additional codes may be assigned as may be dictated by need and negotiation agreements. For implementation of disposition codes, see exhibits 7 through 11.

No. of Columns	
4	Part B Entitlement Date. This is the year and month that the beneficiary became entitled to Part B supplementary medical insurance payments. It shows the last 2 digits of the year followed by 2 digits for the month. When the month has only one digit, it is preceded by a zero.
6	Beneficiary's Date of Birth. This is extracted from SSA's record. It will show 2 digits for the year, 2 digits for the month, and 2 digits for the day. When only one digit is needed, it is preceded with a zero.
4	Remaining Deductible. This is the amount of the deductible that has not been satisfied prior to the present inquiry.
1	Record Code. The record mark "‡" means the end of the reply. There are seven other record codes (1 through 7) that are used when more data follows. The record codes and the fields and field lengths that they precede and identify are explained below.

NOTE: The record from 1 through 20 is fixed. The field(s) from 21 through 34 are also fixed except when certain disposition codes are used. The character in 35 either indicates that the record terminates or it identifies the next field. From 36 on, the various available fields are fixed lengths but some, all, or none may be used depending on the need. Whatever ones are used will appear in the order shown below.

No. of Columns	
10	Intermediary Control Number. (A record code of "1" precedes this field.) This is simply a repeat of 10 characters of alphanumeric data that the intermediary included in the inquiry.
11	Corrected Surname of Beneficiary. (A record code of "2" precedes this field and the following one for initials.) This field will be used only if the name in the query was incorrect. Unused columns are left blank.
2	Initials of Beneficiary. This shows the first initial and middle initial. If there is no middle initial, the column will be blank.
12	Corrected HI Claim Number. (A record code of "3" precedes this field.) This is the beneficiary's corrected HI claim number. It is furnished only if the number in the query was incorrect.
5	Reasonable Charges for Psychiatric Care Remaining. (A record code of "4" precedes this field.) This is $500 (maximum reasonable charges that can be considered) less reasonable psychiatric care charges reported in queries received prior to the present query.
	OR
	Welfare or Intermediary No. (A record code of "6" precedes this field.) If no reply can be given because benefit claims must clear through a special intermediary, the disposition code of "46" will appear in columns 19 and 20, and the identification number of the responsible intermediary will be given in this field.
4	Part B Termination Year and Month. (A record code of "5" precedes this field.) This is the last month in which expenses incurred by the beneficiary are covered by Part B. Expenses incurred through the last day of the indicated month are reimbursable. When the disposition code is "02," this field gives the year and

No. of Columns	
	month of death. It shows the last 2 digits of the year and the digits for the month. If the month is one digit only, it is preceded by a zero. For example, "6801" is shown for January 1968.
1	Blank.
135	Representative Payee. (A record code of "7" precedes this field.) If SSA has a record of someone authorized to act on behalf of the beneficiary, the name and address is transmitted here.
4	Blank.
1	Record Mark to Terminate Record.

Example of Use of Record Codes. The following data may appear from column 35 on: 112345678903124403120A 7 (135 positions of the name and address of the representative payee)‡

The "1" indicates that the intermediary control field follows.

The "3" indicates that the corrected HI claim number follows.

The "7" indicates that the name and address of the representative payee follows.

The record mark indicates that the record ends here.

6235. ADVANCED RECORD SYSTEM (ARS) REPLY RECORD FORMAT (See exhibits 12 through 19.) SSA uses a period (.) to terminate each field except:

a. an asterisk (*) is shown instead of a period at the end of a field containing data that was incorrect in the query, and

b. no period is shown after the last field in each line, although an asterisk is placed there when appropriate.

A field is not split between two lines. SSA separates replies by five blank lines. The data is transmitted in the order indicated below.

Type of Reply Indications. The type of reply code is always shown as the first position in the first line of a reply. There are four types of replies:

Type 3 - Acknowledgment only. SSA is unable to locate the beneficiary's record on the basis of the HI claim number or beneficiary name furnished in the query. SSA is investigating and will send a type 4 or 6 reply within a few days.

Type 4 - Rejected in edit. SSA uses a code of 4 to reject a query because of incorrect data. The intermediary should requery with the correct data.

Type 6 - Routine reply. The 6 indicates the beginning of a routine reply about Part B benefits. Check the disposition code for qualified replies.

Type 7 - Automatic notification. SSA uses a 7 indication to notify the intermediary when Part B entitlement has ended for reasons other than death, or when there is a change in the representative payee information. (This method of notification may not be in force initially, in which case a hard copy of the information will be mailed to the intermediary.)

No. of Positions	
5	Intermediary Number. This is a 5-digit number assigned by SSA to the intermediary.
12	HI Claim Number. This is the beneficiary's claim number, which may vary from 7 to 12 positions. The field is 12 positions; any unused positions following the seventh position will be blank.
2	Disposition Code. This is a 2-digit number that describes the reply. SSA uses the same disposition codes (from 00 through 47) for the ARS wires as they do for magnetic tape transmissions (see § 6234).
4	Part B Entitlement Date. This is the month and year that the beneficiary became entitled to Part B supplementary medical insurance payments. SSA transmits two digits for the month and the last two digits of the year. When the month is one digit, it will be preceded with an "0." Example: for September 1969, SSA shows 0969.

No. of Positions

6 Beneficiary's Date of Birth. This information is taken from SSA records and is transmitted with two positions each for the month, day, and year. Example: for January 27, 1900, SSA transmits 012700.

4 Part B Remaining Deductible. This is the amount of the deductible that has not been met prior to receipt of the present query.

NOTE: Data that is transmitted only in certain replies, as needed, is preceded by a trailer record code to indicate its presence and what it is. In any Part B reply, none, one, or more trailer record codes may be present. The trailer record codes and the fields that they precede are shown below.

No. of Positions

10 Intermediary Control Number. A record code of A precedes this field. This is a repeat of the control number that the intermediary included in the query.

14 Corrected Surname. A record code of B precedes this field. A corrected surname is shown only if the name of the beneficiary submitted in the query is incorrect.

12 Corrected HI Claim Number. A trailer record code of C precedes this field. The corrected number is included only if the HI claim number submitted in the query is incorrect.

5 Reasonable Charges Remaining for Psychiatric Care. A trailer record code of D precedes this field. This is $500.00 (maximum incurred expenses) less reasonable charges for psychiatric care reported in queries received prior to the present query. The amount reported in the present query has not been deducted.

5 Welfare Intermediary Number. A record code of E precedes this field. If no reply can be given because benefit claims must be handled by a welfare agency, this field will show the identification number for the special intermediary. The disposition code in the reply will be 46.

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No. of Positions

4 Part B Termination Month and Year. A record of F precedes this field. SSA transmits 2 digits for the last month covered and the last 2 digits of the year. Expenses incurred through the last day of this month are reimbursable.

1 or 2 lines Representative Payee. A record code of G precedes this field. When SSA has knowledge that someone is authorized to act on behalf of the beneficiary, the name and address is transmitted here.

NOTE: The beneficiary's name and the representative payee's name may not be electronically selected in a data processing system. Although both names may appear in the lines preceding the first line of address, the location of the names and the terms used are not consistent in SSA's source records. Representative payee information contains a maximum of six lines of name and address. Each line is separated by a comma and has a maximum of 22 characters. For example, the data may appear as follows: NEW HAMPSHIRE, STATE HOSP, FOR JOHN N SMITH, 225 PLEASANT ST, CONCORD NH.

6299. EXHIBITS

Exhibit 1. Magnetic Tape - Part B Query - Record Layout.
Exhibit 2. Magnetic Tape - Part B Query Input Format.
Exhibit 3. Query Input Magnetic Tape Header and Trailer Data.
Exhibit 4. Part B Inquiry Coding Sheet.
Exhibit 5. Magnetic Tape Part B Query Reply Output Format.
Exhibit 6. Query Reply Output Magnetic Tape Header and Trailer.
Exhibits 7 through 11. Part B Replies - Record Layout - Magnetic tape.
Exhibit 12. SSA's Magnetic Tape Record of a Type 6 Reply.
Exhibits 13 and 14. Examples of Part B ARS Message Replies as They May Appear on Hard Copy at the Receiving Station.
Exhibit 15. SSA's Magnetic Tape Record of a Type 3 and Type 4 Reply.
Exhibits 16 and 17. Examples of Part B ARS Message Replies as They May Appear on Hard Copy at the Receiving Station.
Exhibit 18. SSA's Magnetic Tape Record of a Type [illegible] Reply
Exhibit 19. Example of Part B ARS Message Reply as it may Appear on Hard Copy at the Receiving Station.

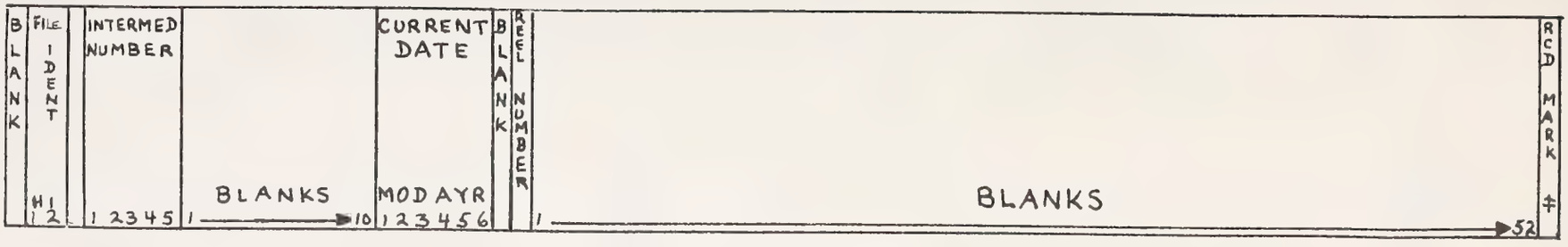
MAGNETIC TAPE – PART B QUERY – RECORD LAYOUT

HI CLAIM NUMBER	SURNAME	INITIALS	QUERY CODE	SEX	INTER-MEDIARY NUMBER	INTERMEDIARY CONTROL NUMBER	JAN. THRU SEPT.			OCT. THRU DEC.			*
							1ST DATE	REGULAR MEDICAL EXPENSES	PSYCH EXPENSES	1ST DATE	REGULAR MEDICAL EXPENSES	PSYCH EXPENSES	
1→12	1→11	2			1→5	1→10	1→3	1→6	1→5	1→3	1→6	1→5	1→10

*The query record may be terminated by:
All record marks in positions 71 thru 75,
Blanks in 71 thru 74 with a record mark in 75,
Record marks in 71 thru 80, or
Blanks in 71 thru 79 with a record mark in 80.

MAGNETIC TAPE – PART B QUERY INPUT FORMAT

TAPE REEL HEADER



TAPE REEL TRAILER



TAPE REEL FORMAT



Exhibit 2

QUERY INPUT MAGNETIC TAPE HEADER AND TRAILER DATA

Columns		Data	Description
		HEADER	
1	(1)	Blank	
2-3	(2)	HI	File Identification
4	(1)	Blank	
5-9	(5)	XXXXX	Intermediary Number
10-19	(10)	Blanks	
20-25	(6)	XXXXXX	Current date (month, day and year)
26	(1)	Blank	
27	(1)	Reel Number	1, 2, etc.
28-79	(52)	Blanks	
80	(1)	‡	Record Mark
		TRAILER	
1-5	(5)	1␣␣␣b	Trailer Label Identifier (1, three lozenges and a blank)
6	(1)	R or F	Termination Code "R" (end of reel) "F" (end of file)
7-12	(6)	XXXXX‡	File Record Count (number of queries on tape)
13-79	(67)	Blanks	
80	(1)	‡	Record Mark

PART B – INQUIRY CODING SHEET

PREFIX	INTERMEDIARY NO.	INTERMEDIARY CONTROL NO.	TYPE QUERY
(II)	IN	IC	TQ

CLAIM NUMBER HOLDER		INITIALS	SEX			CLAIM NUMBER
CH			M	F	UNK	CN
			1	2	3	

JANUARY THROUGH SEPTEMBER

DATE FIRST INCURRED			REASONABLE CHARGE	REASONABLE PSYCH. CHARGE
	MO.	YEAR		
SI			RC	PC

OCTOBER THROUGH DECEMBER

DATE FIRST INCURRED			REASONABLE CHARGE	REASONABLE PSYCH. CHARGE
	MO.	YEAR		
CD			CC	CP

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Exhibit 4

MAGNETIC TAPE – PART B QUERY REPLY OUTPUT FORMAT

TAPE REEL HEADER



TAPE REEL TRAILER



TAPE REEL FORMAT



Exhibit 5

QUERY REPLY OUTPUT MAGNETIC TAPE HEADER AND TRAILER

Columns	Data	Description
	HEADER	
1 (1)	Blank	
2-4 (3)	SSA	File Identification
5-9 (5)	XXXXX	Intermediary Number
10-19(10)	Blanks	
20-25 (6)	XXXXXX	Current Date (month, day and year)
26 (1)	Blank	
27 (1)	Reel Number	1, 2, etc.
28-79(52)	Blanks	
80 (1)	‡	Record Mark
	TRAILER	
1-5 (5)	1␣␣␣b	Trailer Label Identifier (1, three lozenges and a blank)
6 (1)	R or F	Termination Code "R" (end of reel) "F" (end of file)
7-12 (6)	XXXXX‡	File Record Count (number of replies on tape)
13-79(67)	Blanks	
80 (1)	‡	Record Mark

PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

The examples below contain the information that SSA will furnish when the disposition code is one of the following:

00 - SSA is investigating. A definitive reply will follow.

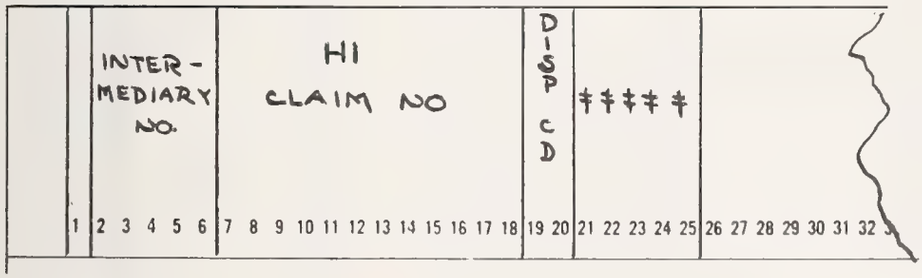
42 - Rejected, because the individual did not sign up for part B.

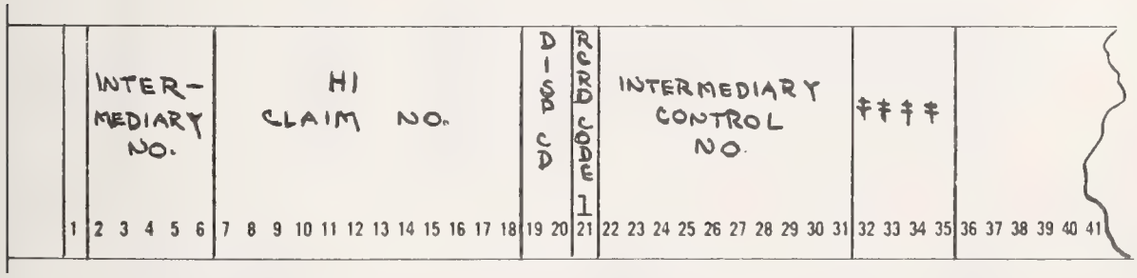
45 - Rejected, because SSA cannot find the record from the information given. The intermediary is to recheck name and HI claim number and retransmit.

47 - Rejected, because query code C or E was received without the counterpart.

81 thru 87 - Rejected, because of error in:

81 - HI claim number
82 - Query code
83 - Name
84 - First date incurred
85 - Reasonable charges
86 - Reasonable psychiatric charges
87 - Carry-over data





(A record code of 1 precedes the intermediary control number field.)

PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

Formats for replies with disposition codes 01, 02, 21, 22, or 41. See opposite page for explanations of disposition codes.

		INTER-MEDIARY NO	HI CLAIM NO	DISP CD	ENTMO		BIRTH DATE			DEDUCT STATUS	‡	
					YR	MO	YR	MO	DA			
	1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21 22	23 24	25 26	27 28	29 30	31 32 33 34	35	36 37 38 39 40 41 42

		INTER-MEDIARY NO	HI CLAIM NO	DISP CD	ENTMO		BIRTH DATE			DEDUCT STATUS	RCRD CD 1	INTERMEDIARY CONTROL NO	RCRD CD 2	CORRECTED NAME	‡	
					YR	MO	YR	MO	DA							
	1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21 22	23 24	25 26	27 28	29 30	31 32 33 34	35	36 37 38 39 40 41 42 43 44 45	46	47 48 49 50 51 52 53 54 55 56 57 58 59	60	61 62 63 64

		INTER-MEDIARY NO	HI CLAIM NO	DISP CD	ENTMO		BIRTH DATE			DEDUCT STATUS	RCRD CD 3	CORRECTED CLAIM NO.	RCRD CD 4	REIMB. PSYCH EXP	‡‡	
					YR	MO	YR	MO	DA							
	1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21 22	23 24	25 26	27 28	29 30	31 32 33 34	35	36 37 38 39 40 41 42 43 44 45 46 47	48	49 50 51 52 53	54 55	56 57 58 59 60 61

PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

The SSA reply will appear as one of the examples on the opposite page when the disposition code is one of the following:

Disposition Code

01	Approval. A reply with this disposition code contains the data requested in the query.	
02	Approval. The reply contains the data requested but also indicates the beneficiary's entitlement has been terminated by death. (The year and month of death field is preceded by a record code of 5.)	
21	Acknowledgment. SSA has received and posted the query that was query coded A (void credit).	When the reply includes disposition code 21 or 22, SSA gives the status after the account has been adjusted on the basis of the current query. In all other replies status is prior to receipt of the query.
22	Acknowledgment. SSA has received and posted the queries with query codes of C and E (Adjustment credit).	
41	Rejected. The "first date incurred" reported in the query is prior to the entitlement date. When the disposition code is 41, the deductible status field will always show blanks.	

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PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

Examples of replies containing disposition code 44.

When SSA rejects a query because the claimant's entitlement to part B has terminated for a reason other than death, the format of the reply will appear as one of the following:

		INTER-MEDIARY NO	HI CLAIM NO	DISP CD	RCRD CODE D 1	INTERMEDIARY CONTROL NO.	RCRD CD 5	TERM DT YR	TERM DT MO	####	
	1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21	22 23 24 25 26 27 28 29 30 31	32	33 34	35 36	37 38 39 40	41 42 43 44 45 46

In the above example the intermediary furnished an intermediary control number in the query; in the example below he did not. A record code of 1 precedes the intermediary control number. A record code of 5 precedes the field for the termination date.

		INTER-MEDIARY NO	HI CLAIM NO	DISP CD	RCRD CODE 5	TERM DT YR	TERM DT MO	#####	
	1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21	22 23	24 25	26 27 28 29 30	31 32 33 34 35 36 37 38 39

PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

Example of a reply containing disposition code 46.

When the query is rejected by SSA because the claimant is serviced by a special intermediary, the reply will appear as one of the following:

	INTER-MEDIARY NO.	HI CLAIM NO.	DISP CD	RCRD CD	INTERMEDIARY CONTROL NO.	RCRD CD	SPEC INTER	‡‡‡	
1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21	22 23 24 25 26 27 28 29 30 31	32	33 34 35 36 37	38 39 40	41 42 43 44 45 46 47 48 49 50
				1		6			

In the above example the intermediary furnished an intermediary control number in the query; in the example below, he did not. A record code of 1 precedes the intermediary control number and a record code of 6 precedes the field for the special intermediary number.

	INTER-MEDIARY NO	HI CLAIM NO.	DISP CD	RCRD CODE	SPEC INTER	‡‡‡‡	
1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21	22 23 24 25 26	27 28 29 30	31 32 33 34 35 36 37 38 39 40 41
				6			

PART B REPLIES--RECORD LAYOUT--MAGNETIC TAPE

This is an example of an SSA reply that contains all record codes except 6, (which is for a special intermediary; see other exhibits).

	INTER-MEDIARY NO.	HI CLAIM NO,	DISP CD	ENT MO		BIRTH DATE			DEDUCT STATUS	RCRD CODE 1	INTERMEDIARY CONTROL NO	RCRD CODE 2	CORRECTED NAME		RCRD CODE 3	CORRECTED CLAIM NO.	RCRD CODE 4	REIMB. PSYCH EXP
				YR	MO	YR	MO	DA					SURNAME	INIT				
1	2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18	19 20	21 22	23 24	25 26	27 28	29 30	31 32 33 34	35	36 37 38 39 40 41 42 43 44 45	46	47 48 49 50 51 52 53 54 55 56 57	58 59	60	61 62 63 64 65 66 67 68 69 70 71 72	73	74 75 76 77 78

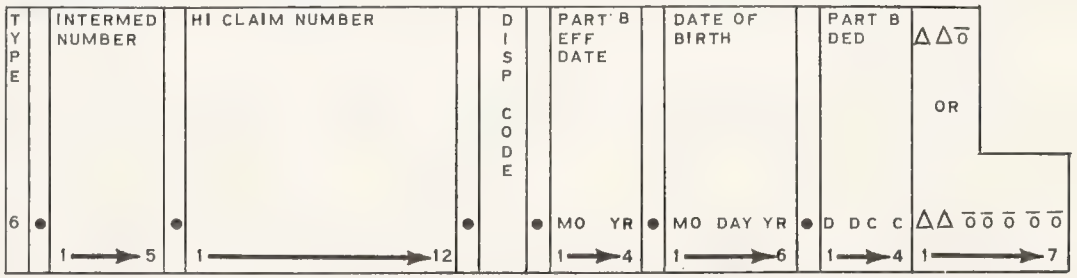
RCRD CODE 5	TERM DT		RCRD CODE 7	REDRESENTATIVE PAYEE NAME AND ADDRESS
	YR	MO		
1	2 3	4 5	6	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

REPRESENTATIVE PAYEE NAME AND ADDRESS (CONT.)	*
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61	62 63

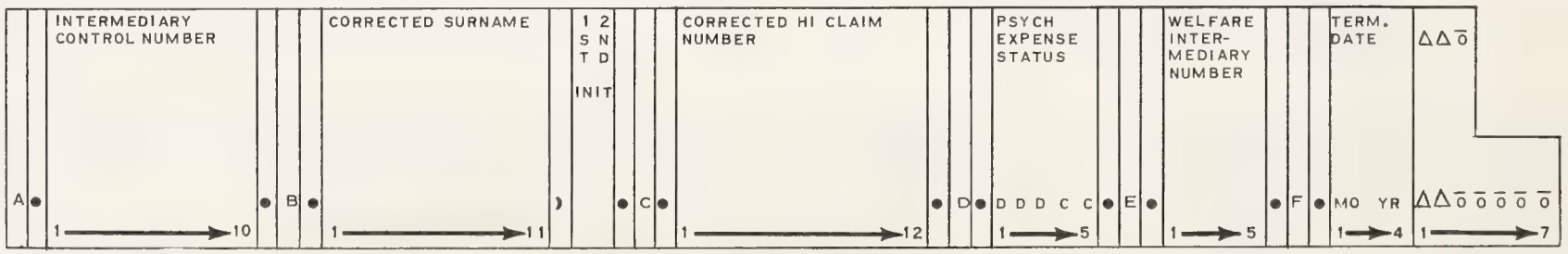
NOTE: Representative payee information contains a maximum of six lines of name and address. Each line is separated by a comma. Each of the lines varies in length with a maximum of 22 characters between commas. The last line of address may terminate immediately before the carriage return character or may contain from 1 to 4 blanks between the last character of the last line of address and the carriage return.

SSA'S MAGNETIC TAPE RECORD OF A TYPE 6 REPLY

TYPE 6 REPLY – PART B DEDUCTIBLE/PSYCHIATRIC STATUS



TYPE 6 REPLY – MISCELLANEOUS TRAILERS "A" THROUGH "F"



EXAMPLES OF PART B ARS MESSAGE REPLIES AS THEY MAY APPEAR ON HARD COPY AT THE RECEIVING STATION

TYPE 6 REPLIES--PART B DEDUCTIBLE/PSYCHIATRIC STATUS REPLY

Example 1:

```
6.01212.049077395A  .01.0866.081201.5000
A.1234567891.C.049707395A
G.CONSUELLA G DAVIS &,PIERINA F ARSENA,GDNS OF,
MARIA C BASILE,59 WRIGHT ST,NEW BERLIN N Y
```

Position

1	Type of Reply Code (6)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code (01--gives unqualified data)
25-28	Part B Effective Date
30-35	Date of Birth
37-40	Part B Deductible To Be Met
	Line #2 if Needed
1	Part B Trailer Record Code (A)
3-12	Intermediary Control Number
14	Second Trailer Record Code (C)
16-27	HI Claim Number Correction
	Line #3 if Needed
1	Part B Trailer Record Code (G)
3-69	First Line of Representative Payee Information
	Line #4 if Needed
1-69	Second Line of Representative Payee Information

EXAMPLES OF PART B ARS MESSAGE REPLIES AS THEY MAY APPEAR ON HARD COPY AT THE RECEIVING STATION

TYPE 6 REPLIES--PART B DEDUCTIBLE/PSYCHIATRIC STATUS REPLY. (cont.)

Example 2:

6.01212.287104904A .46.A.1357924680.E.21005

Position

1	Type of Reply Code (6)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code: "46" signals that status is not furnished to the intermediary who queried because the beneficiary is serviced by a welfare intermediary.
25	Part B Trailer Record Code (A)
27-36	Intermediary Control Number
38	Part B Trailer Record Code (E)
40-44	Welfare Intermediary Number

Example 3:

6.01212.100141628B .01.0766.102081.5000
B.MCCADDEN ,LJ.D.50000

Position

1	Type of Reply Code (6)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-28	Part B Effective Date
30-35	Date of Birth
37-40	Part B Deductible
	Line #2 if Needed
1	Part B Trailer Record Code (B)
3-16	Name Correction
18	Part B Trailer Record Code (D)
20-24	Noninpatient Psychiatric Expense Status

EXAMPLE OF PART B ARS MESSAGE REPLY AS IT MAY APPEAR ON HARD COPY AT THE RECEIVING STATION

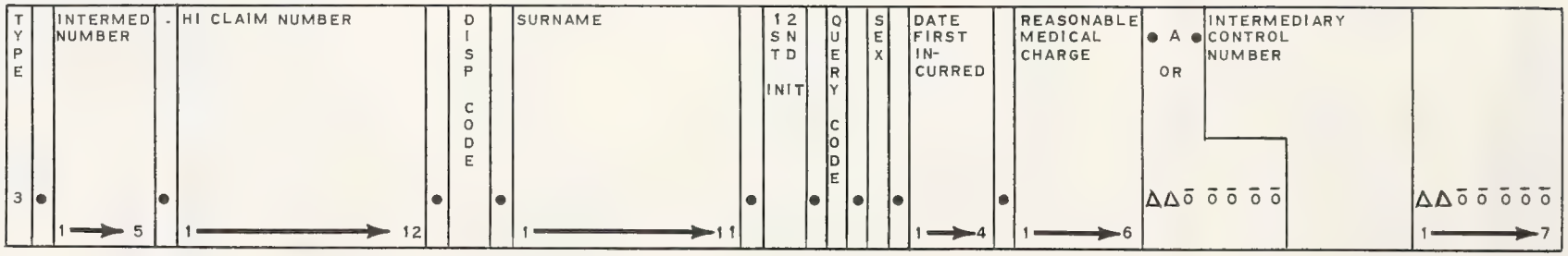
TYPE 3 REPLY--QUERY ACKNOWLEDGMENT. SSA is unable to locate the record based on the HI claim number and/or name given in the query. SSA is investigating; type 4 or 6 reply will follow.

3.01212.387129686B .00.MEYER ,AW.I.1.0766.034265

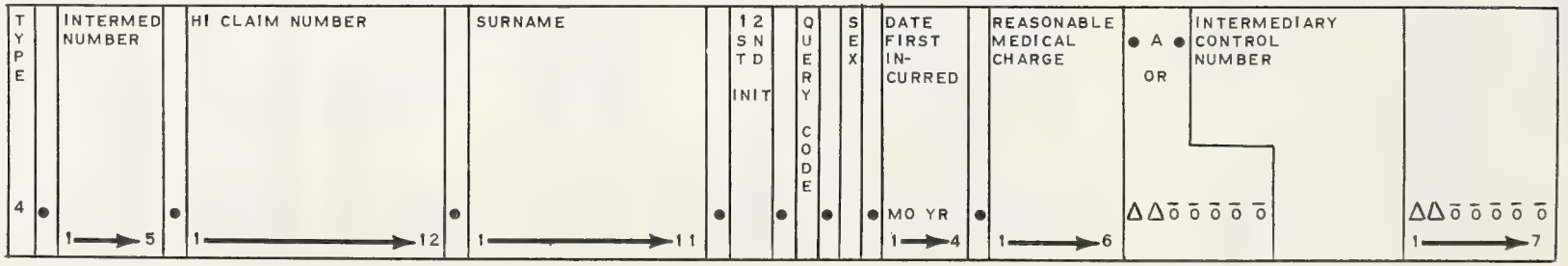
Position		
1	Type of Reply Code (3)	
3-7	Intermediary Number	
9-20	HI Claim Number	
22-23	Disposition Code	
25-35	Surname	
36	Comma	
37-38	First Initial, Middle Initial	
40	Query Code (This is a repeat of the query code furnished in the query.)	
42	Sex	
44-47	Month Service Incurred	
49-54	Reasonable Charges	
56	Part B Trailer Record Code (A)	These would be added if the intermediary control number was furnished in the query.
58-67	Intermediary Control Number	

SSA'S MAGNETIC TAPE RECORD OF A TYPE 3 AND TYPE 4 REPLY

TYPE 3 REPLY – QUERY ACKNOWLEDGMENT. SSA IS UNABLE TO LOCATE RECORD ON BASIS OF HI CLAIM NUMBER AND/OR NAME SUBMITTED.



TYPE 4 REPLY – REJECTION OF QUERY DURING INITIAL EDIT.



EXAMPLE OF PART B ARS MESSAGE REPLY AS IT MAY APPEAR ON HARD COPY AT THE RECEIVING STATION

TYPE 4 REPLY--REJECTION OF QUERY BY SSA DURING INITIAL QUERY EDIT.

4.01212.396031217D .LANGE ,RT.I.1.0866.00750A*10000
A.1296066109

Position

1	Type of Reply Code (4)
3-7	Intermediary Number
9-20	HI Claim Number
22-32	Surname
33	Comma
34-35	First Initial, Middle Initial
37	Query Code (This is a repeat of the query code given in the query.)
39	Sex
41-44	Month Service Incurred
46-51	Reasonable Charge
52	The Asterisk (*) Denotes Query Transmission Error in Preceding Field
53-57	Reasonable Charges Noninpatient Psychiatric

Line #2 if Needed

1	Trailer Record Code (A)	Shown when the intermediary control number was furnished in the query.
3-12	Intermediary Control Number	

EXAMPLE OF PART B MESSAGE REPLY AS IT MAY APPEAR ON HARD COPY AT RECEIVING STATION

TYPE 4 REPLY--REJECTION OF QUERY BY SSA DURING INITIAL QUERY EDIT. (For example, when a letter appears in a field that should be all numbers.)

```
4.01212.375123456HB  .BASILE       ,MC.I.2.0766.010150.05000
1066.005000.02G50*A.1234509876
```

Position

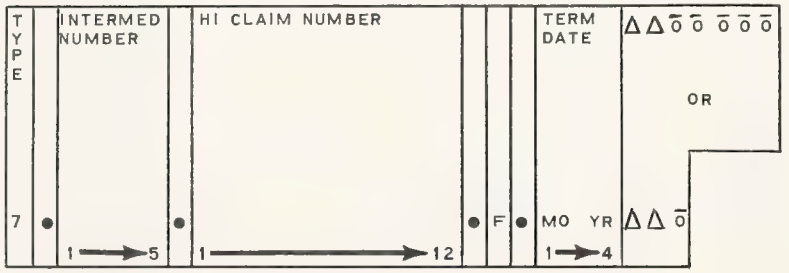
1	Type of Reply (4)
3-7	Intermediary Number
9-20	HI Claim Number
22-32	Surname
33	Comma
34-35	First Initial, Middle Initial
37	Query Code (This is a repeat of the query code given in the query.)
39	Sex
41-44	Month Service Incurred
46-51	Reasonable Charge
53-57	Reasonable Charges Noninpatient Psychiatric

Line #2 if Needed

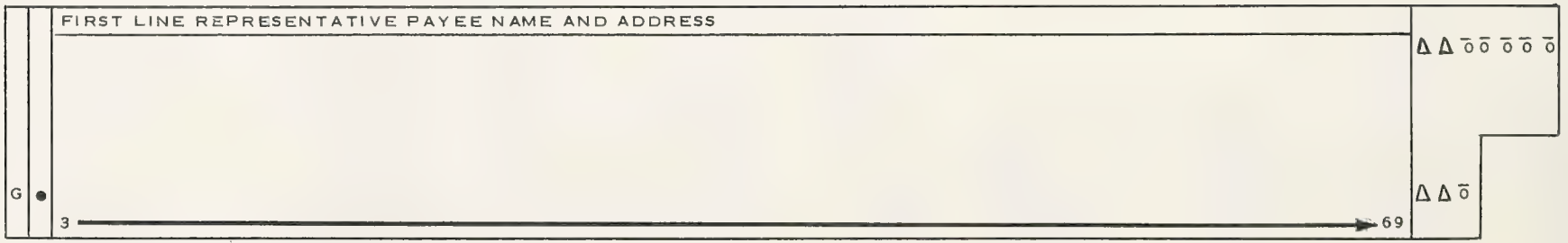
1-4	Month Service Incurred (Oct.-Dec.)
6-11	Reasonable Charges (Oct.-Dec.)
13-17	Reasonable Charges Noninpatient Psychiatric (Oct.-Dec.)
18	The Asterisk (*) Denotes Query Transmission Error in Preceding Field
19	Trailer Record Code (A)
21-30	Intermediary Control Number

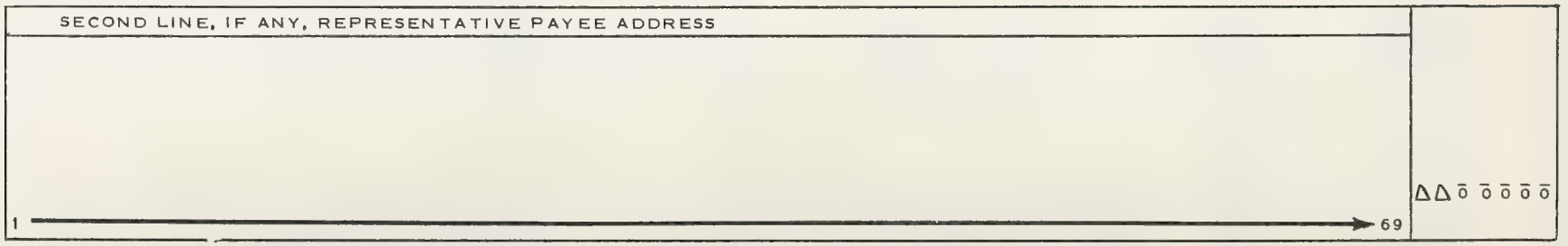
SSA'S MAGNETIC TAPE RECORD OF A TYPE 7 REPLY

TYPE 7 REPLY – MESSAGE TO UPDATE INTERMEDIARY STATUS FILE



"G" TRAILER THAT MAY FOLLOW A TYPE 6 OR TYPE 7 REPLY*





*Representative payee information contains a maximum of six lines of name and address. Each line is separated by a comma. Each of the lines varies in length with a maximum of 22 characters between commas. The last line of address may terminate immediately before the carriage return character or may contain from 1 to 4 blanks between the last character of the last line of address and the carriage return.

EXAMPLE OF PART B ARS MESSAGE REPLY AS IT MAY APPEAR ON HARD COPY AT THE RECEIVING STATION

TYPE 7 REPLY--MESSAGE TO UPDATE INTERMEDIARY STATUS FILE. When the trailer record code is F, the message gives the month and year that Part B entitlement ended for a reason other than death. Trailer record code G indicates the representative payee information has changed.

7.01212.422223223D .F.1166
G.JOHN B MALONEY AS,CONS OF,ETHEL E HALL,
CHURCH ST,GROVETON N H

Position	
1	Type of Reply Code (7)
3-7	Intermediary Number
9-20	HI Claim Number
22	Trailer Record Code (F)[1]
24-27	Termination Date
	Line #2
1	Trailer Record Code (G)[1]
3-69	Representative Payee Information

1/ The trailer record code may be F or G, or both, but the representative payee information will always begin on the second line.

6400 – Payment and Postpayment Procedures

6500 – Reports and Statistics

6600 – Transmittal and Maintenance of Claims Records

6300 – Bill Review

CHAPTER IV

BILL REVIEW

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6301. BILL REVIEW - GENERAL
When Part B non-provider services have been furnished, the beneficiary supplier, or physician will forward the forms SSA-1490, Request for Payment, to the Part B intermediary. If physicians' services are billed through a provider, that provider will attach the SSA-1554, Provider Billing for Patient Services by Physicians, to its regular billing form. When the Part A intermediary receives the two billing forms, it will take its necessary action on the regular billing form for provider services and attach the SSA-1554 to the "Carrier" copy of the provider services billing.

The carrier will determine the amount payable for the non-provider Part B services. Its certification that payment is proper should be based upon the data on the billing form and any attachments, as well as additional documentation or supportive information which is required to resolve questions arising from its bill review function.

The carrier must take the necessary steps to reconcile any inconsistencies encountered in its review. Issues involving apparent inconsistencies between diagnoses and treatment and any other questions relating to the reasonableness of items or services rendered by physicians should be reviewed by the carrier's medical staff. Bill review techniques developed as a result of the carrier's experience may be used or adapted for operations applicable to this program.

6303. DATING OF REQUEST FOR PAYMENT FORMS
Each request for payment form (SSA-1490, 1490A or SSA-1554) should show the date of receipt by the carrier in the top margin, in the center of the form. Dates should be entered numerically showing month (2 digits), day (2 digits), and the last position, of year (1 digit). For example, November 25, 1966, would be entered 11-25-6.

The date of approval of payment must be shown on at least those forms included in the continuous sample of bills transmitted to the Social Security Administration. See §6520.3 for the manner in which this requirement may be satisfied. This entry will be used for processing time data.

6305. COPIES OF PROVIDER SERVICES BILLS
The Part B intermediary will receive a "Carrier" copy of the hospital billing form from the Part A intermediary. This copy is intended to serve as a supplemental source of information in determining reasonable charges in claims involving physicians' services. The length of stay in the hospital, diagnosis and surgical procedures can be

especially helpful information when Part II of the Request for Payment form has not been completed because the patient is seeking reimbursement on the basis of a receipted bill. See § 6330 for use of the "Carrier" copy in reviewing provider billings for physicians' services.

"Carrier" copies of Part A bills will be forwarded to the intermediary for physician services in all cases. The Part B intermediary should retain these copies readily retrievable for study purposes. Where the intermediary for physicians' services has access to files of the intermediary for provider services or maintains mutual files, there may be no need for physical transmission of paper. In such cases, the intermediary for physician services should work out with the intermediary for provider services disposition of "Carrier" copies of Part A bills.

Normally, the Part B intermediary who serves the area in which the services were rendered or items were furnished will review and make payment for Part B services. Therefore, when a provider billing form is received without a billing form for a hospital-based physician, the "Carrier" copy should be forwarded to the Part B intermediary servicing the address of the attending physician (as named in item 9 of the billing form). However, where the provider bills for a physician, the Part B intermediary servicing the area in which the provider is located will review and make payment for the Part B services, irrespective of the location of the physician's principal or other office.

6307. RECONTACTS WITH PHYSICIANS OR SUPPLIERS AND PATIENTS FOR ADDITIONAL INFORMATION

There will be occasions when additional information must be secured to resolve a question on the Request for Payment form. Intermediaries should be guided by their experience in deciding how the additional information or proofs can best be secured. Factors such as the nature of the additional information required, the source to which the request must be directed, and whether the method chosen will insure prompt responses will be important considerations in deciding how the contact is to be made.

If the Request for Payment is submitted to the intermediary and items of information are missing, it will not be necessary for the intermediary to recontact the source submitting the bill unless the missing information is pertinent to the processing of the claim. As a general rule, requests for payment and receipted bills submitted by physicians and other medical suppliers or by beneficiaries, that contain enough information, and in sufficient detail, to permit intermediaries to make

determinations of reasonable charges will contain enough information to satisfy statistical needs. If, of course, a contact must be made in order to process a claim, then all missing information should be secured.

Where, as a result of development undertaken by the intermediary, additional information which was needed to make a payment has been secured, the additional information should be clearly reflected in the file.

6309. CHARGES BY A RELATIVE OR MEMBER OF THE IMMEDIATE HOUSEHOLD
When the patient is charged for services by a member of the patient's household or by an immediate relative, no health insurance payment can be made. Hence, intermediaries, in reviewing Requests for Payment, will have to resolve any questions that raise this issue; e.g., the surname and/or residence of the patient and that of the physician or supplier is the same. See § 6120.11 for a definition of "members of the patient's household" and "immediate relative."

6311. DUPLICATE AND/OR OVERLAPPING BILLS WITH DISCREPANT CHARGES
Occasionally, an intermediary will receive a bill which, on the basis of incurred dates or other entries on the bill or in the intermediary's file, duplicates an earlier bill except that the amount of payment which is requested varies from the services rendered or the health items furnished.

Discrepant charges may also be revealed when a later bill not only duplicates an earlier bill, but is also a Request for Payment for additional services rendered or new health items furnished.

Where such discrepant charges are discovered, the necessary development should be undertaken to ensure that the proper payment has or will be made.

Where corrections or adjustments are made after the intermediary has forwarded a payment record to the Social Security Administration, it will be necessary to prepare a corrected payment record sufficiently identified as such so that the Social Security Administration can adjust its records.

6314. DEVICES TO OBTAIN PAYMENT THROUGH DECEPTION
The possibility of fraud through altered receipted bills should not be overlooked. The Social Security Administration anticipates that the procedures normally used by intermediaries to screen claims will be sufficient to discover altered bills or identify forged signatures.

Of course, if doubt arises as to the authenticity of a particular claim, the intermediary will undertake appropriate development to resolve any questions which are raised. When development is completed and there is either evidence of fraud or an indication that fraud may exist, submit a memorandum to Bureau of Health Insurance, Division of Policy and Standards, setting forth the circumstances of the case and attach copies of appropriate material relevant to the issue.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R730

Copy from your HEALTH INSURANCE CARD

NAME OF BENEFICIARY *(Patient)*

CLAIM NUMBER

☐ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. *(You do not need to complete this item if your doctor completes Part II below)*

2. Was your illness or injury connected with your employment? ☐ YES ☐ NO

3. Are you attaching itemized receipted bills? ☐ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☐ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE *(Patient or authorized representative)* — DATE SIGNED

6. ADDRESS *(Street address, City, State, ZIP Code)* — TELEPHONE NUMBER

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN— This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE[1]	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES *(Diagnosis)*	E. CHARGES	Leave Blank
				$	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER *(Number and street, City, State, ZIP Code)*

TELEPHONE NUMBER

CODE NO.

9. Total Charges	$
10. Amount Paid	$
11. Any Unpaid Balance Due	$

12. ASSIGNMENT OF PATIENT'S BILL *(See reverse)* ☐ I ACCEPT ASSIGNMENT ☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER *(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)* ☐ MD ☐ DO ☐ DDS OR DMD — DATE SIGNED

[1] O—Doctor's Office IH—Inpatient Hospital ECF—Extended Care Facility OL—Other Locations *(Specify in 7C)*
IL—Independent Laboratory *(give name and address in 7C)* H—Patient's Home OH—Outpatient Hospital NH—Nursing Home

FORM SSA-1490 (4-66)

3-101

6400 – Payment and Postpayment Procedures
6500 – Reports and Statistics
6600 – Transmittal and Maintenance of Claims Records

INSTRUCTIONS—PLEASE READ BEFORE COMPLETING THE OTHER SIDE OF THIS FORM

GENERAL INSTRUCTIONS

MEDICAL INSURANCE PAYS—80 percent of the reasonable charges for physicians' services and medical supplies, **except the first $50 each calendar year** (called the $50 deductible). Reasonable charges are determined by the organization which pays the claim, taking into account the customary charges made by the doctor and the prevailing (usual) charges of doctors in the locality.

Example of Payment: A beneficiary has doctor bills of $500 during a calendar year. The first $50 will **not** be paid by medical insurance; the beneficiary is responsible for this deductible amount. Of the remaining $450, medical insurance will pay 80 percent, or $360, and the beneficiary is responsible for 20 percent, or $90.

DEDUCTIBLE—The $50 deductible applies each calendar year. **No expenses before the beneficiary's medical insurance coverage date can be used for the deductible.** This date is shown on the beneficiary's health insurance card. Be sure to read the full explanation of the deductible in YOUR MEDICARE HANDBOOK, especially to find out how expenses in the last 3 months of one year may sometimes be used for the deductible in the next year.

Since the medical insurance plan does not pay for any part of the $50 deductible, it is recommended that the first claim each year not be filed until the deductible has been met for that year.

HOW TO CLAIM—This form can be used to claim payment in either of two ways:

1. **Payment to the patient**—after he has paid his doctor or supplier; or
2. **Payment to the doctor or supplier**—for unpaid charges, if both the patient and the doctor or supplier agree to this method of payment, called the "assignment" method.

PAYMENT TO THE PATIENT

The beneficiary (patient) should complete Part I of this claims form. He should be sure to sign and date it. If he cannot sign his name, he should make an X and have it witnessed. The witness should show **his** own name and address on the signature line. If the beneficiary cannot make the claim for himself, his authorized representative should show the beneficiary's name and "By" followed by his own signature and address.

Itemized receipted bills, including bills for the deductible amount, must be attached to the claims form, unless the doctor prefers to complete Part II. If itemized bills are attached, THEY MUST SHOW:

- Name of person or organization furnishing the medical services or supplies. If they were not furnished by a physician, the name of the physician who prescribed the services or supplies should be shown.
- Name of patient receiving services or supplies.
- Each date services or supplies were provided.
- Place services were provided (home, office, hospital, etc.). If provided in an **independent** laboratory, its name and address must be shown.
- A description of the services or supplies provided on each occasion. If the bill is for ambulance service, it should show the origin and destination.
- The charges for each medical service or item.
- The receipt showing the bill was paid may be on the bill or attached to it. Please do not send cancelled checks.
- To help speed handling of claims, the claim number should be written on each bill.

PAYMENT TO THE DOCTOR OR SUPPLIER

If all or any part of a medical bill has not yet been paid, the patient may assign his medical insurance benefit payment so that payment can be made directly to the physician (or supplier). However, **both** the patient and the physician (or supplier) must agree to this "assignment" method of payment. Under the Social Security Act, the physician or supplier who accepts an assignment also agrees to accept the reasonable charge as his full charge. (Reasonable charge determinations are made by the organization which makes medical insurance payments.) The patient, of course, is still responsible for the $50 deductible and 20 percent of the remainder.

If this method is used, the patient should complete Part I of this claims form and check "Yes" in item 4. The physician (or supplier) should complete Part II and check the box in item 12 to show his acceptance of the beneficiary's assignment.

INSTRUCTIONS TO PHYSICIAN OR SUPPLIER FOR COMPLETING PART II

For each date in item 7, the physician should describe any medical or surgical procedure, attaching a supplementary statement if necessary. If more than one procedure or treatment was provided on a single date, describe each procedure separately. Include any charges for preoperative and postoperative care in surgical charges. If the services or supplies were **not** furnished by a physician, the supplier should show in item 7-D the name of the physician prescribing them whenever Part II is completed. A report for ambulance service should show the origin and destination in item 7-C. Space is provided for a physician identification number to facilitate processing of the claim by the organization making payment.

The doctor or supplier may attach itemized or machine-prepared bills which contain the same information required by item 7 of the form. The patient's claim number should be shown on each bill. The physician may show his diagnosis either on the bill or in item 7.

MAILING INSTRUCTIONS

Mail this form to the organization handling medical insurance benefits in the area where the medical services or items were furnished. The nearest social security district office will be glad to help anyone who calls, writes, or telephones for assistance in filing his claim. If it is more convenient, you may get help from the organization designated to handle medical insurance benefits for your area.

FOR MORE INFORMATION

For more information, please refer to YOUR MEDICARE HANDBOOK. If you have a question about the way a particular claim was handled, you should get in touch with the organization which made the payment or with the nearest social security district office.

6325. THE REQUEST FOR PAYMENT FORM (SSA-1490 AND 1490A)
The Request for Payment claims form (SSA-1490 and 1490A) is designed to show:

1. The name and other identifying information of the patient receiving the services or supplies.

2. The name of the person or organization providing the medical services. If not furnished by a physician, the name of the physician who prescribed the services or supplies must be shown.

3. A description of each medical and surgical procedure and any supplies furnished.

4. Each date the services were provided.

5. The charges for each medical service or item.

6. Location where the services or supplies were provided (e.g., home, office, hospital, etc.). If provided in an independent laboratory, its name and address must be shown.

7. Whether or not the illness or injury was employment-related.

6325.1 Identification Items on Form SSA-1490.--Part B Intermediary Identification Item: The intermediary may enter its name and address in the space provided in the upper left corner. The entry may be printed by the intermediary. (The intermediary number will also be shown in this space when a continuous sample bill is forwarded to the Social Security Administration, see §6515.)

Name of Beneficiary: The beneficiary's name should be shown and should be checked against Item 5, "Signature," to assure that the bill reflects services to the proper beneficiary.

Claim Number: The claim number shown in this item should be checked for consistency with the claim number shown on the reply to the deductible status query, the reply to any status query, or the claim number used in a prior claim action. The claim number may be an indication that another carrier has jurisdiction, i.e., railroad retirement beneficiaries. The claim number should be entered on accompanying receipts or other developmental information received.

Sex: Check this item to see that an entry is made and that it is correct.

6325.2 Part I of Form SSA-1490--Claims Information.

Item 1: The patient's description of his illness or injury is used to supplement the information on itemized receipted bills in determining whether the services or supplies were covered and the charges reasonable.

Item 2: Investigate "Yes" and omitted answers on employment connection (see §6420ff).

Item 3: Examine attached itemized receipted bills for acceptability as payment data and as meeting the same requirements as to dates and places of each service; procedures and services for each date given; diagnosis, etc.--outlined under item 7.

In some nonassignment cases, the physician or supplier may complete Part II of the form instead of attaching separate itemized receipted bills. In such cases, the form SSA-1490 must indicate the equivalent "receipted" status of the bill.

Item 4: When there is a mutual agreement with respect to assign-
Item 12: ment blocks should be answered in the affirmative and signed by both the patient or his authorized representative and the physician or supplier. A doubtful or incomplete item, or any question relating to the proper execution of the request should be investigated in accordance with §6010ff.

Item 5: The address is furnished to assist in necessary contact
Item 6: with the patient; to furnish him with a copy of the "Explanation of Benefits" form (and the address for the check or draft in direct payment cases) on completion of the intermediary's review actions; and in conjunction with the address of the physician, to assist the intermediary in determining whether it has jurisdiction of the claim.

Item 6 should also show the patient's or authorized representative's telephone number. This is provided for the intermediary's use in resolving any question arising on the claim for which expeditious contact with the signatory is desired.

6325.3 Part II of Form SSA-1490--Report of Services.--If the physician submits an itemized or machine-prepared bill, which contains the same information required by Item 7, he need not recopy or complete this item except that the diagnosis must always be shown either in 7D or on the itemized bill.

The physician or supplier must clearly identify any surgical or medical procedure in order to relate more closely the procedure or service to the charge. Item 7C (or a bill in lieu of 7C) should include charges for preoperative as well as postoperative care. Preoperative care as used here means consultations with the surgeon to determine the nature and necessity of the surgery.

If the doctor attaches a copy of his operative notes in lieu of completing item 7C, this will usually suffice.

If the doctor describes more than one type of service on a single date, but combines the charges, the intermediary may have to contact the doctor for itemized charges in order to properly assess the reasonable charges. If the services were not furnished by a physician, the supplier should show the name of the physician who prescribed them in item 7D whenever Part II is completed.

Item 7A: If the same services are furnished on different dates of service, each date is to be shown; the other identical entries may be dittoes.

Compare the dates of service with the Part B entitlement date furnished by the Social Security Administration to eliminate services furnished before the first month of entitlement. Also check against the intermediary file for possible duplication of claims.

Services for which payment is being requested should occur on or after the date the individual's coverage became effective. In addition, although the individual's coverage may have been terminated either at his request, because of nonpayment of premium, or by death, payment may nevertheless be made for any covered services received during his coverage period prior to termination.

Each intermediary who has received a query reply that a patient's deductible has been met in a given year will be notified if the patient's coverage is terminated in that year.

Item 7B: The Place of Service, in accordance with the codes shown in footnote 1 at the bottom of the form, should appear in this item.

In many cases the copy of a hospital billing form, which is forwarded to the Part B intermediary by the Part A intermediary will be available and will provide supplementary information needed to pay for Part B services. If "independent laboratory" is shown, development should be undertaken in accordance with Item 7C, below.

Item 7C: The description for each service or supplies furnished should be complete enough for the intermediary to determine that the charges are reasonable. If the service shown is for ambulance service, the origin and destination should be shown in this item.

If Item 7B shows services by an independent laboratory, the name and address should be entered in this space.

If the claim for payment for laboratory services is submitted by a physician under an assignment and the laboratory is not identified, it may be assumed, in the absence of information to the contrary, e.g., that the test requires special equipment and the physician does not specialize in this field of testing, that the test was done in the laboratory the physician maintains as an adjunct to his own practice. If the beneficiary submits a claim in the form of a receipted bill and laboratory services are claimed but the laboratory is not identified, the patient or physician should be asked to furnish the name of the laboratory. To minimize such contacts, it may be useful for the intermediary to develop and maintain a current file showing the tests particular physicians in the area customarily perform in their own laboratories in connection with the diagnosis and treatment of their own patients' conditions.

As an interim procedure for the period beginning July 1, pending completion of the process of certifying independent laboratories, payment may be made on all proper claims for diagnostic laboratory services involving independent laboratories. However, if the facility is in a State which has licensing requirements the facility must meet applicable State and local licensure requirements. Listings of licensed laboratories should be obtained from

the State agency responsible for licensure. As the certification process progresses, intermediaries will be provided with lists of laboratories which fail to meet the conditions for coverage. No payment may be made to any laboratory appearing on these lists for services rendered after the effective date of the listing.

Within each State, as soon as feasible, a list of laboratories which are in compliance with the conditions of coverage will be issued. When this list becomes available in a State, revised procedures will be issued which will provide that only services rendered by laboratories on the approved list will be reimbursable under the medical insurance program.

When a claim for payment by an unapproved laboratory is denied, payment may still be made for the physician's charge for his professional services in evaluating the test results, even though payment may not be made for the specific tests.

Item 7D: If completed by a physician, the diagnostic entry should be complete enough to determine if the services were covered, reasonable and necessary, or consistent with the entries in item 7C and other related entries. Any inconsistencies which may raise questions about the correctness of the bill should be resolved before payment is made.

If completed by a supplier, this entry should include the full name of the physician prescribing the services or supplies. The signature of the supplier certifies that the physician's request for services or supplies is on file. If the information is not furnished in the patient's claim, the intermediary should secure it before payment is made, unless the SSA-1490 provides sufficient information to warrant a finding that the items or services are not inconsistent with the description of the illness or injury.

Item 7E: These should be the individual itemized charges for each date of service as furnished by the physician or supplier.

Leave Blank: This space is for intermediary use if worksheets or computerized print-outs are not part of the

intermediary's bill processing operations. This space may be used to record the individual and total reasonable charges where they differ from the entries in item 7E.

Item 8: Name and address information is furnished to facilitate dealings with the physician or supplier to enable the carrier to determine whether the supplier of services can qualify for benefit payments, and as an aid in determining jurisdiction and referring the claim to the servicing intermediary where appropriate. In assignment cases, the address will be used for payment purposes.

The telephone number item is provided to facilitate any developmental contact that may be required with either the physician or supplier. The "Code No." item should show the physician's or supplier's identification number. If it is not entered by the physician or supplier, the intermediary will make the appropriate entry which is required for processing of the payment records.

Item 9: This should be the total charges as furnished by the physician or supplier. If the charges shown are determined not to be "reasonable," the necessary adjustment should be made in the "Leave Blank" section, separate worksheet, or be shown in the computer print-out, as appropriate to the intermediary's system.

Item 10: This should be the amount paid to the physician or supplier by the patient or other responsible party.

If an excess deductible or coinsurance amount has been collected by a physician or supplier, the intermediary will make the appropriate adjustment and take the necessary steps to prepare separate checks and "Explanation of Benefits" notices.

Item 11: This item should show the difference between the Total Charges (item 9) and Amount Paid (item 10). Where the amount shown in item 9 was assessed to be the reasonable charge and the amount in item 10 is the proper deductible and coinsurance amount applicable as determined by intermediary records or a query to the Social Security Administration, item 11 would be the full reimbursement

amount due. However, where either item 9 is incorrect or item 10 does not reflect true deductible or coinsurance amounts, the amount shown in item 11 will not be the same as the benefit check.

Item 13: The signature of the physician or supplier should be consistent with the entry in item 8.

Where a medical doctor, doctor of osteopathy, doctor of dental surgery, or doctor of dental medicine signs this item, the appropriate box should be checked.

224-878 O-66—8

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS
MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

Form Approved.
Budget Bureau No. 72-R747

3-110

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*			4. DATE OF BIRTH __ __ \| __ __ \| __ __	5. SEX ☐ M ☐ F
6. NAME AND ADDRESS OF PROVIDER			7. PROVIDER NO(S).	8. MEDICAL RECORD NO.

9. ASSIGNMENT: I assign payment for unpaid charges of the physician(s) listed on this form.

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.
The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.

SIGNATURE OF PATIENT *(Or his representative)* | DATE SIGNED

10A. DATE OF EACH SERVICE	B. NAME OF PHYSICIAN	C. PLACE OF SERVICE IH,OH,ECF,H	D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	E. DEPARTMENT	F. TOTAL CHARGE	G. PERCENT OF TOTAL CHARGE WHEN APPLICABLE	H. CHARGE FOR PHYSICIANS SERVICES	LEAVE BLANK

11. DIAGNOSES AND CONCURRENT CONDITIONS	12. EMPLOYMENT RELATED ☐ YES ☐ NO *(If yes, give name and address of employer)*			
		TOTALS	$	
		Deductible and coinsurance paid		
		Any unpaid balance		

13. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE	DATE

FORM **SSA-1554** (6-66)

6330. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS (FORM SSA-1554)

This single form will suffice for a patient to claim and assign his right to payment for all amounts which are charged by all physicians billing through the hospital for the professional services furnished to the patient. A one-time assignment from the physician on file in the hospital will permit the hospital thereafter to claim these payments on his behalf. The billing need not be made in the name of each physician, where arrangements with the intermediary have been made, it may be done on his behalf in the name of the head of the department.

If Part B physician services are billed through a provider, that provider will attach the SSA-1554, Provider Billing for Patient Services by Physicians, to its regular billing form and forward them to the Part A intermediary. Upon approval of the hospital bill by the Part A intermediary, the SSA-1554 and the Carrier copy of the hospital bill will be forwarded to the Part B intermediary. The hospital bill may be helpful in processing the billing for physicians' services. For example, the Carrier copy of the hospital bill will verify that the hospital's departmental charge is the same as that shown on the bill for hospital-based physicians, and will also furnish back-up surgical and diagnostic information.

Items 1 - 9: In general, these should be completed in a manner similar to related items on the Request for Payment SSA-1490.

Item 10A: Date of Service.--The dates on which each physician service was rendered should be entered here.

Item 10B: Name of Physician.--The name of the physician for whom the provider is billing for services should be shown here. Upon arrangement with the intermediary, billing may be in the name of the hospital department head.

Item 10C: Place of Service.--Codes "IH" for hospital inpatient, "OH" for hospital outpatient, and "ECF" for services furnished in an extended care facility should be entered here.

Item 10D: Surgical or Medical Procedures.--The surgical or medical procedures performed during this billing period as entered in the patient's medical record should be entered here. The surgical or medical procedure should be clearly identified by the use of standard nomenclature; e.g., Current Medical Terminology, Standard Nomenclature of Diseases and Operations.

Item 10E: Department.--The name of the department associated with the physician's services; e.g., emergency room, radiology, or laboratory should be shown here.

Item 10F: Total Charge.--The provider charges should be entered here only if the charge is for both the provider and physician services. Note: Usually, physicians' charges are stated fees directly related to specific services. However, the charges of hospital-based physicians, due to the contractual relationship of physician and provider, may represent either a percentage of total hospital charges, a percentage of a contracted salary, set fees, or charges based upon a per diem rate not related to actual services. A clear understanding of the existing contractual relationship between the provider and physician, and the basis of charges represented on the bills are essential for the Part B intermediary to determine reasonable charges and make proper disposition of these claims.

Item 10G: Percentage of Charge.--For every total charge shown in item 10F, a percentage of the total charge applicable in determining the charges for physicians' services should be entered here.

Item 10H: Charge for Physicians' Services.--Wherever item 10F and 10G have been completed, item 10H will be a money amount arrived at by applying the percentage shown in item "G" by the total charge shown in item "F." Where charges for physicians' services are made without the application of a percentage to a total charge, only the physician's charge should be entered in item 10H. Totals.--All physicians' charges are to be totaled in the "Totals" block, and the provider must enter any deductibles and coinsurance paid by the patient. The difference will be shown in the unpaid balance space.

Leave Blank: This column is for the use of the intermediary if he wishes to enter the individual and total reasonable charge determinations if different from the charges in 10H.

Item 11: Diagnosis and Concurrent Conditions.--The most significant of the conditions should be shown first when diagnoses are entered. Diagnoses should be shown using standard nomenclature; e.g., Current Medical Terminology, Standard Nomenclature of Diseases and Operations.

Item 12: Employment Related.--The provider will indicate whether the condition is employment related. Investigate "Yes" answers and omissions (See §§ 6421).

Item 13: Provider Certification.--The signature of the provider representative should be shown in this item as well as the date the signature was affixed.

6400 – Payment and Postpayment Procedures

6500 – Reports and Statistics

6600 – Transmittal and Maintenance of Claims Records

CHAPTER V

PAYMENT AND POSTPAYMENT PROCEDURES

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Payments

6401. TIMELINESS OF PAYMENT AND PAYMENT RECORDS
Payment should generally be made as soon as possible after completion of the bill review operation and, in the case of beneficiaries, not less frequently than weekly. Where the intermediary has arrangements with the medical profession in the area, to make payments to physicians on a cycle basis, such periodic payments may be made but not less often than once each month.

Payment records representing groups of such bills and documenting such payments should be forwarded, preferably weekly, to reconcile individual blocks and monthly letter of credit totals.

(For preparation of payment records, see chapter VI. For transmittal of payment records, see chapter VII.)

6403. BENEFIT CHECKS
The payment checks will contain the legend:
"For Health Insurance--Social Security Act."

If an intermediary is also administering the Title XIX program for a State, the intermediary will not combine payments under Titles XVIII and XIX in a single check.

6405. REIMBURSEMENT ON THE BASIS OF A PARTIALLY PAID BILL
Reimbursement may be made to an enrollee on the basis of a partial payment of the amount of the bill, where such partial payment is at least $25, or if less is the full amount due on a reasonable charge. However, if the bill has been assigned, see 6406 below.

Any unmet part of the deductible will be considered met, to the extent possible, from the unpaid portion of the reasonable charges. The amount of reimbursement will then be 80% of the amount paid toward the reasonable charge, after reduction by any part of the deductible still unmet.

Thus, if the beneficiary has paid only $20 toward a bill on which the reasonable charge is $95, no payment may be made to him. If he has previously met the deductible and pays the bill in installments of $20, he may submit receipts for $40 after having paid the second installment, and may then either submit receipts for $40 after the fourth installment and $15 after the fifth and last, or, preferably, submit receipts for $55 after the last installment. He would be paid $32 on the basis of the $40 receipts, and the total payable is $76.

If the beneficiary had not met any part of the deductible, the

maximum amount payable on this bill is $36, and this maximum may be paid him upon proof that he has paid at least $45 of the $95 bill (since $50 of the unpaid portion of the reasonable charges may be applied to meet the deductible).

If the beneficiary had previously met $30 of the deductible, $20 of the unpaid portion of the bill could be applied toward the deductible, and he may be paid 80 percent of any amount of $25 or more that he has paid, up to a maximum of $60 when he has paid at least $75 of the $95 bill.

6406. ASSIGNMENT OF A PARTIALLY PAID BILL

A person may assign, and a physician (or other nonprovider furnishing Part B services) may accept assignment of, a partially paid bill. In such a situation, the Part B payment will be divided between the physician (or other person) and the enrollee as follows: The physician will be paid any amount due under Part B, except the excess (if any) by which such amount, when added to the amount paid by the enrollee, will exceed the reasonable charge.

Thus, if an enrollee has paid his physician $50 of a bill on which the reasonable charge is $125, the physician can receive no more than $75 of the Part B payment. Assuming that the deductible had previously been met, $100 (80 percent of the reasonable charge) is payable, and the physician will receive $75.

Any excess not payable to the physician will be paid to the enrollee.

Example 1: The intermediary receives an assigned bill for $300, on which the enrollee has paid $100. The reasonable charge is $300 and $25 of the deductible has previously been met. Total payment due is 80 percent of $275 ($300 minus the remaining $25 of the deductible), or $220. Of this amount, $200 will be paid to the physician (the difference between the $100 he has already received, and the $300 amount of the reasonable charge). The other $20 will be paid to the enrollee.

Example 2: The assigned bill totals $325, of which amount the enrollee paid $250. The reasonable charge is found to be $250; no part of the deductible has been met.

The amount payable under Part B is 80 percent of $200 ($250 reasonable charges minus the $50 deductible), or $160. The $160 is payable to

the enrollee; no part of this amount is payable to the physician, since the enrollee has already paid him the full reasonable charge. In this situation, the physician will gain nothing by the assignment, and retains the right to bill the enrollee for the balance of his bill, $75.

6408. PARTIAL REIMBURSEMENT IN CASES PENDING FURTHER DEVELOPMENT
Payment by the intermediary of a nonassigned bill may be delayed because additional information or proofs have not been submitted; e.g., a questionable item on a bill has not been verified because a physician who must supply additional information is unavailable. Partial payment may be made by the intermediary in such cases where the circumstances warrant it. Normally, the following circumstances must be present to warrant partial reimbursement:

1. Thirty days have elapsed since receipt of the bill by the intermediary and there will be significant further delay before all the information, which will be needed to make a full payment, will be received.

2. The specific payment to be made is not directly related to or dependent on the approval of the missing information.

3. The amount that can be immediately paid is not less than $20.

The intermediary may also consider the possibility of partial reimbursement in any case where a beneficiary inquires about delay or there is an indication of hardship to the beneficiary.

Overpayments and Underpayments

6415. OVERPAYMENTS
Overpayments to beneficiaries, physicians, or suppliers may occasionally occur. Where a payment record submitted to SSA was incorrect, immediate action should be taken to correct such payment record, whether or not a refund is obtained. Payment records on subsequent claims, from which the amount of the overpayment is deducted, should reflect the gross amount due rather than any adjusted amount.

The law provides that an incorrect payment will not be recovered from a beneficiary who is without fault and where the recovery would defeat the purposes of title II (the old-age, disability,

and survivors insurance provisions of the Social Security Act) or would be against equity and good conscience.

The following sections indicate the appropriate action required in obtaining refund of overpayments.

6415.1 Overpayment to Beneficiary in Direct Payment Situations.-- Overpayments are handled slightly differently when the individual is entitled to health insurance benefits only, than when he is also entitled to monthly social security old-age or survivors benefits. (When the enrollee's health insurance claim number ends with "T," "M," or "M1," he is entitled only to health insurance benefits; see § 6204.1. The possible health insurance claim numbers for individuals who are also entitled to monthly benefits are listed in §§ 6204.1 and 6204.2.)

The carrier should offset an overpayment made directly to a health insurance-only beneficiary against any current claim for direct payment received from that beneficiary. When offset is not possible because there is no current claim for direct payment from him, the carrier should request a refund. When the individual's health insurance claim number indicates that he is entitled to monthly social security benefits, the carrier should request a refund, but should not apply offset against any current claim for health insurance benefits from that individual.

When an offset of $25 or more is applied (when appropriate), or a refund of $25 or more is requested, the explanation to the beneficiary of the offset or requested refund should include the following:

> "You may not have to pay back the money if both of the following statements apply in your case: (or, 'The amount withheld may be returned to you if both the following are true:')
>
> 1. The overpayment was made to you through no fault of your own.
>
> 2. Paying it back would keep you from meeting your ordinary and necessary living expenses; or would be unfair for some other reason, that is, by means of the overpayment you gave up a valuable right or changed your position for the worse."

If the individual responds that the conditions in 1. and 2. above are true, forward copies of the correspondence promptly to the

Social Security Administration
Bureau of Health Insurance
Division of Policy and Standards
Room 4-R-3, Social Security Building
Baltimore, Maryland 21235

Include any additional information that would be helpful in assessing the circumstances of the overpayment.

In all other cases where the overpayment has not been satisfied in full within 30 days after the date of the letter of explanation, the carrier should forward a report to SSA at the above address. (The only exception is when the enrollee is appealing the correctness of the intermediary's decision.) The report should give the amount and circumstances of the overpayment together with any correspondence received from the beneficiary. The intermediary will be notified of the disposition of the issue.

6415.2 Overpayment to Physician or Supplier in Assignment Situations. The intermediary should request r fund of the overpayment from the physician or supplier or the overpayment may be offset against any Part B payment otherwise due the physician or supplier.

6415.3 Overpayment to Beneficiary, Physician, or Supplier Who Is Deceased.--Where overpayment has been made to a beneficiary who has since died, the amount and circumstances of the overpayment should be forwarded to the Bureau of Health Insurance, Division of Policy and Standards. Where the physician or supplier has been overpaid, the intermediary should forward a report of the overpayment and the circumstances surrounding such overpayment to the same address.

6418. UNDERPAYMENTS ARISING OUT OF DEATH SITUATIONS
Situations will occur where an individual dies after having established his right to payments under the medical insurance program and before such payment is made. In these cases, the payment of the amount due must be made to the legal representative of the individual's estate. A new Request for Payment form is not necessary. No payment should be made to some other person because he was the representative payee for the deceased and underpaid individual. If there is no legal representative, the payment cannot be made. In cases where a check is released to an individual prior to his death, no action need be taken to stop payment or cancel the check unless a protest is made or the check is returned. However, the intermediary should not knowingly issue any check in favor of an individual who has died. (An assignment made before death can be honored without consulting the legal representative.)

The intermediary should determine the identity of the legal representative of the estate in order to make proper payment. The appointment papers should be obtained. A check payable to the "estate of John Doe," would not be an appropriate disposition of the unpaid amount due. If no representative has been appointed, the intermediary should consider the possibility that a survivor or other person may qualify under a small estate statute. (Under the "small estate" statutes of many States, an individual can be appointed by a court to collect, receive, and distribute the assets of an estate not exceeding a certain size. An individual appointed under a small estates statute will be considered a legal representative for the purpose of making payments after the death of a beneficiary.)

Where an underpayment cannot be acquitted under the procedure described above, a full report of the amount and circumstances of the underpayment should be made to the Division of Policy and Standards, Bureau of Health Insurance, in Baltimore.

Workmen's Compensation

6420. GENERAL INFORMATION

Payment under the Health Insurance for the Aged Act is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion is applicable to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, as well as the systems provided under the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

The Act requires that any health insurance payment for items or services is to be conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment for such item or service has been made under workmen's compensation.

There is no election between workmen's compensation and health insurance. The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where payment under that system can reasonably be expected. Failure to take proper and timely action under such circumstances will preclude payment under the health insurance program to the extent that payment could reasonably have been expected to be made under workmen's compensation had the individual exhausted his benefit rights under that system.

Payments made under workmen's compensation for items and services otherwise covered under health insurance may not be counted toward deductibles or coinsurance amounts required under health insurance.

6421. GENERAL PROCEDURES IN HANDLING WORKMEN'S COMPENSATION CASES

Each carrier should use its own experience in formulating procedures for handling and control of cases involving workmen's compensation. Procedures must necessarily be adapted to the varying requirements of the laws of the several jurisdictions. However, the following general guidelines are furnished.

The answer to question No. 2 on the Request for Payment (Form SSA-1490) will provide positive indication of a work-related illness or injury. If the item is not answered, the nature and circumstances of an injury or illness or the nature of treatment may suggest an employment relationship. In other cases information available to the carrier concerning prior workmen's compensation payments on behalf of the individual will suggest the probability that subsequent care for the same injury or illness will also be compensable under workmen's compensation.

The carrier should in cases of possible workmen's compensation involvement initiate any necessary investigation or development to resolve the issue.

6421.1 Carrier's Investigation.--Upon receipt of an indication that a work-related injury or disease may be involved, the intermediary should undertake the investigation and development necessary to support its determination. It may utilize its usual investigative methods and procedures and may seek information from the beneficiary, his employer, providers of services, provider intermediaries, other medical insurance carriers, the workmen's compensation carrier, or the State workmen's compensation agency.

In many cases a provider intermediary will be the first on notice of possible workmen's compensation. The carrier should coordinate its investigation and determination regarding reasonable expectation of workmen's compensation payment with any other carrier or intermediaries known to be concerned with the claim. It is important that there be consistency in the determinations of carriers and intermediaries concerning the implications of workmen's compensation as related to the same injury or illness.

The carrier's investigation should be carried out as promptly as possible since a delayed determination by the carrier that workmen's compensation payments can reasonably be expected coupled with a failure by the patient to file under that system, may result in his loss of benefits under both workmen's compensation and the health insurance program.

6421.2 Intermediary's Determination and Related Procedures

A. Workmen's Compensation Has Been or Is Being Paid.--If the carrier's investigation reveals that workmen's compensation payment has been or is being made which fully covers the cost of the items and services furnished, no payment under the health insurance program may be made.

Where payment under workmen's compensation is less than that which could reasonably be expected under that system, payment under health insurance would be offset to the extent of workmen's compensation payment reasonably expected and not simply to the extent of the actual payment made under that system.

Where a lump sum compromise is awarded as payment of a workmen's compensation claim, the amount of payment for hospital and medical expenses may or may not be specified in such a settlement.

However, it is not necessary to examine the settlement to determine the items or services for which payment has been made since the only consideration is the benefits which could reasonably have been expected had the individual pursued his right to payment for medical services under workmen's compensation. Thus, in those States where there is no limitation on workmen's compensation payment for hospital and medical expenses, no payment could be made under the health insurance program for services required by a work-related injury or disease where a lump sum compromise has been effected.

The carrier should give written notice of its decision to the beneficiary and to any assignee of the beneficiary. The carrier should document the case file with the facts bearing on its decision.

B. Workmen's Compensation is Reasonably Expected.--Based on its investigation the carrier must make a determination as to whether workmen's compensation payment can reasonably be expected, and, if so, it must determine the amount reasonably expected.

Should the carrier determine that there is a reasonable expectation that a workmen's compensation payment will be made for the beneficiary's care, the carrier should notify the beneficiary and any assignee that health insurance payments are precluded due to the expectation of workmen's compensation coverage. The notice should also indicate that the case may be reopened in the event workmen's compensation does not pay. If the individual has not yet filed a claim under workmen's compensation, the carrier should advise him to file such a claim and inform him that failure to pursue his claim under workmen's compensation will preclude payment under health insurance to the extent that payment could reasonably have been expected had he done so.

The carrier should document the file with the facts which were considered in making its determination.

C. Workmen's Compensation is Questionable.--Should the carrier determine that workmen's compensation payments cannot reasonably be expected, payment under health insurance may be made on condition that such payment will be refunded in the event workmen's compensation later pays for the services. However, such conditional payment should not be made unless there is a real question as to whether payment will be made by workmen's compensation. The mere fact that the employer or workmen's compensation carrier is contesting liability would not in itself

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be a sufficient basis for making payment under health insurance if investigation indicates that the individual can reasonably expect workmen's compensation payment if he pursues his claim.

6422. OVERPAYMENTS
When information is received that workmen's compensation payments have been made subsequent to the payment of health insurance benefits for the same items and services, the health insurance payment becomes an overpayment. This should be handled in accord with § 6415.

Notification of Payment

6430. NOTICE OF PAYMENT AND NONPAYMENT
One of the important functions that intermediaries perform under the medical insurance program is to notify each beneficiary of the action taken on his Request for Payment whether submitted directly or by a doctor accepting assignment. The notice is needed to explain the transaction to the beneficiary and to give him the opportunity to appeal the determination. In addition, it may be used by the beneficiary to furnish information to complementary carriers and welfare departments. The notice will serve as a record for the beneficiary and will be of use as evidence that the deductible has been satisfied or partially satisfied.

Each intermediary will be free to design the notice in a format suited to its own equipment and method of operation. However, the following items should appear on all notices:

1. Title of form - "Explanation of Benefits (Medical Insurance, Title XVIII, Social Security Act)"

2. Intermediary's name and address

3. Date

4. Beneficiary's name and address (need not be repeated if the beneficiary is the payee)

5. Beneficiary's health insurance number

6. Payee's name and address

7. Dates services were received

8. Places services were received

9. Description of services received (not necessary to identify source of services when only one service is involved)

In describing the services involved consideration should be given to striking a balance between being specific enough to enable the beneficiary to identify the service, yet general enough to avoid revealing sensitive information.

10. Total charges - the full amount of the charge for each service

11. Charges not allowed - All adjustments made to the "Total Charges" other than the deductible and coinsurance

12. Allowed charges - Total charges less charges not allowed

13. Amount of deductible and coinsurance

14. Amount of medical insurance benefits paid

15. Amount for which patient is responsible

16. Remarks section - to explain any of the above

17. Specified general information. See Exhibit 1

The Bureau of Health Insurance reviews the form that the intermediary uses, in advance of its being printed.

In assignment cases, a copy of the notice will be sent to the doctor or supplier involved as well as to the beneficiary. In cases involving payment directly to the beneficiary, the doctor or supplier will not receive a copy of the notice.

Exhibit 2 shows sample paragraphs of statements to explain total charges not allowed, and paragraphs which indicate the beneficiary's claim has been disallowed. Intermediaries may prefer to use a separate disallowance letter rather than include this in the Explanation of Benefits. It is important that the letter clearly

states the reasons for the denial, the place where the beneficiary can secure additional information or explanations, and a review of the determination.

EXHIBIT 1

A. If you have questions about the benefits payable under the Medical Insurance Program, your nearest social security district office will be glad to assist you. If you have a problem or question about the way this claim was handled, you may write or get in touch with (the carrier) at the address shown at the top of this report form. (The carrier) will be glad to give your request full consideration and will provide you with additional information as to what action you may take if you are still not satisfied. Always show your Health Insurance Claim Number when writing about your claim.

B. If you have other health insurance, this notice may be useful to you in claiming any benefits payable by the other health insurance organization.

C. This notice includes only information about medical insurance benefits which were requested on the Request for Payment form recently filed by you or your doctor (or supplier). If you have other medical expenses on dates and at places other than shown on this form, you will receive separate notice.

D. This notice can be used to indicate the status of the $50 deductible to your doctor or anyone else from whom you request services.

EXHIBIT 2

SAMPLE PARAGRAPHS FOR USE IN REMARKS SECTION
OF EXPLANATION OF BENEFITS FORM

1. Noncovered Charges

Charges for (description of service or supplies) are not covered under the health insurance program. Therefore, no payment can be made for these expenses.

2. Charges Greater Than Reasonable

The charges for (description of service or supply) have been reduced to the amount indicated because they have been determined to be higher than is permitted by law.

3. Psychiatric Limitation

a. The charges for (description of service) had to be reduced because only 62½ percent of expenses for psychiatric services are allowed under the law.

b. The charges for (description of service) have been reduced because the maximum for psychiatric services payable in a calendar year has been exceeded.

4. Transfer of Bill

The request for payment that was submitted includes services that were rendered outside of the area serviced by this company. We have submitted that portion of the bill referring to services outside our area to the organization that services that area, the _____, City, State. They will process that part of your claim. You will hear directly from them about the services furnished in their area.

5. Deductible Not Met

No payment can be made under the medical insurance plan until you have incurred $50 in expenses. According to our record, as of the date of this notice, you have incurred $_____ toward the deductible for the year 19__. You may wish to hold any future bills until you have incurred $50 in expenses.

6. Part B Enrollee Premiums Not Paid

Our records indicate that your coverage has been terminated because premium payments have not been received for your account; therefore, benefits are not payable.

7. Split Payment

Enclosed is a check for $____. The remainder of the payment of $_____ was made directly to (doctor or supplier) . The basis for these payments is as follows: _____.

8. Workmen's Compensation Payments Expected

It has been determined that there is a reasonable likelihood that a workmen's compensation payment will be made for the medical services or supplies for which you requested payment. The law does not permit any payment to be made if workmen's compensation payment is expected. Your case may be reopened if workmen's compensation does not make payment.

Disclosure of Information

6440. DISCLOSURE OF INFORMATION--GENERAL

In the administration of the health insurance law, the Administration, intermediaries, providers of service, and State agencies acquire information about beneficiaries and about institutions and organizations which are participating, or have been denied, participation in the program. This information, for the most part, is acquired under circumstances in which the individual, institution, organization, etc., furnishing the information expects it to be kept confidential. Section 1106 of the Social Security Act and the rules and policies formulated by the Administration under Regulation No. 1 recognize the basic legislative pledge of confidentiality given the public.

6442. THE PROHIBITION AGAINST DISCLOSURE

Section 1106 of the Social Security Act prohibits disclosure of any file, record, report, or other paper, or any information obtained at any time by the Secretary or an officer or employee of the Department of Health, Education, and Welfare in the course of discharging his duties under the Social Security Act, except as prescribed by regulations. The same prohibition applies to information received from the Secretary or an officer or employee of the Department. The routine medical records of a patient in the possession of a provider or physician are not bound by the prohibition or by Departmental rules and regulations concerning confidentiality simply because the patient is entitled to benefits under this program. These records, however, may be subject to applicable State or local laws, or hospital rules governing disclosure.

The prohibitions noted above apply also to any agency, organization, e.g. an intermediary, or institution, or any of its officers or employees, in the fulfillment of a contract or agreement with the Secretary.

The prohibition also relates to any information received from the Department or an intermediary by any person or entity which furnishes services under arrangements with a provider; or accepts an assignment under the medical insurance program.

6444. THE AUTHORITY FOR DISCLOSURE

Regulation No. 1 contains the basic authorization for disclosure of information obtained in the administration of the program, from which rules and policies have been developed. The general rule is that information about an individual, organization, institution, etc., obtained in the administration of the program, may not be disclosed without the authorization of the individual, organization, institution, etc., to whom the information relates. Medical information relating to an individual will generally be disclosed under

more restrictive conditions than other information and where permitted, may be furnished only upon the authorization of the source of the information as well as the individual. Specific exceptions to this general rule are set out in detail in the following sections; however, as far as the program is concerned, information about an individual, organization, or institution may be disclosed without the authorization of the individual, organization, or institution, when the disclosure is necessary in connection with any claim or other proceeding under the law.

Disclosure of information for other than program purposes will be made only if disclosure is authorized by Regulation No. 1 and is consistent with the proper and efficient administration of the program.

6445. DISCLOSURE NECESSARY FOR PROPER ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

A. Information About an Individual.--Disclosure of any record, report, or information about an individual may be made, without the authorization of the individual, in connection with any claim or other proceeding under the Act when such disclosure is necessary for the proper performance of the duties of:

1. Any officer or employee of the Department; or

2. Any officer or employee of a State agency, intermediary, provider of services or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

B. Information About Hospitals, Extended Care Facilities, Home Health Agencies.--Information about a hospital, extended care facility or home health agency, as well as information about an independent laboratory, may be disclosed without authorization by the institution or organization when such disclosure is required for the proper performance of the duties of:

1. An officer or employee of the Department;

2. An officer or employee of an intermediary; or

3. An officer or employee of a State agency when necessary to carry out his duties under State law in the licensing or approving of hospitals, extended care facilities, home health agencies, or independent laboratories.

Information obtained in the provider certification process is not to be disclosed to those not included in the above three categories. This prohibition encompasses information such as the fact that a particular identified hospital has or has not applied for participation in the program; the progress that a hospital is making towards being approved; that survey findings on a particular hospital are favorable or unfavorable; that a hospital is certified for approval but is deficient in some respects; or that a particular hospital has been found not in compliance with the conditions of participation, etc. Anyone not among the above three categories requesting information about the status of an institution or agency which is not on the list as a participating provider of services is to be referred to the institution for the information regarding its status.

6447. DISCLOSURE OF INFORMATION TO AN INDIVIDUAL OR HIS AUTHORIZED REPRESENTATIVE

A. Nonmedical Information.--Nonmedical information directly relating to an individual may be disclosed, in form and detail consistent with proper and efficient administration of the program, to the individual or his authorized representative when reasonably necessary for a program purpose. For all other purposes disclosure is conditional upon administrative feasibility.

B. Medical Information.--Medical information about an individual obtained in the administration of the program may be disclosed, in form and detail consistent with proper and efficient administration of the program, to the individual or to his authorized representative when disclosure is reasonably necessary for a program purpose. However, medical information about the individual is not to be disclosed to him if knowledge of it would be detrimental to him.

Disclosure of medical information for other than a program purpose is not permitted under the present regulations, but the Administration is considering the question of amending the regulations to provide for disclosure for other than a program purpose when the information is necessary for a determination of the benefits the individual may be eligible for under another health insurance program; however, such disclosure would be made only if the source of the medical information authorizes it.

6448. DISCLOSURE TO THIRD PARTIES FOR OTHER THAN PROGRAM PURPOSES

A. Nonmedical Benefit Information.--Nonmedical benefit information about an individual may be disclosed for other than a

program purpose, to persons or organizations designated by the individual, if the individual authorizes disclosure, and if disclosure is consistent with the proper and efficient administration of the Act.

B. Medical Information.--Disclosure of medical information for other than a program purpose is not permitted under the present regulations, but the Administration is considering the question of amending the regulations to provide for disclosure when the information is necessary for a determination of the amount of benefits or services an individual may be eligible for under a hospital or medical insurance plan, a group health plan, a complementary insurance plan, etc., which has been determined to be consistent with the purposes and objectives of the health insurance law, but only if the source of such medical information or, if the source is not available, a physician in the employ of the Department, consents to disclosure and the individual involved or his authorized representative consents to disclosure.

C. Information an Intermediary Is Not Authorized to Use or Disclose.--In the light of the above rules, a participating intermediary which is also writing complementary insurance, or administering an employee or union group health plan, may not in its capacity as intermediary release information obtained in connection with the administration of the health insurance program to itself in its capacity as private insurance writer or administrator, for nonprogram activities. Without first satisfying the appropriate rules discussed above, the intermediary, for example, may not use information obtained in the administration of the program for making payment under its complementary insurance plan. Further, under no circumstances may an intermediary use the knowledge of an individual's entitlement under the health insurance program, obtained in the course of performing its program functions, for purposes of sales leads; use entitlement or benefit utilization information for purposes of dropping an individual from a group health insurance plan; or integrate an individual's complementary insurance record with his health insurance record.

6450. DISCLOSURE TO STATE AGENCIES ADMINISTERING PROGRAMS RECEIVING FEDERAL GRANTS-IN-AID

Welfare agencies have been instructed to make arrangements with carriers on a local basis for providing Title XVIII information to help expedite welfare agency medical payments.

A. Nonmedical Benefit Information.--Nonmedical benefit information such as entitlement, benefit payments, or benefit utilization relating to an individual may be disclosed to any officer or employee of a State agency charged with the administration of grants-

in-aid programs under titles I, IV, V, X, XIV, XVI, or XIX of the Social Security Act without the authorization of the individual or his authorized representative.

B. Medical Information.--The general rule is that medical information relating to an individual (and obtained in the administration of the health insurance program) may be disclosed to a State agency administering the grants-in-aid programs cited above, with written authorization of the beneficiary and the physician or provider.

6453. DISCLOSURE OF STATISTICAL AND OTHER INFORMATION
Statistical data and similar information which does not relate to any identifiable person or persons and which can be compiled from the records regularly maintained for administrative purposes may be disclosed if efficient administration permits disclosure. Statistical data and similar information shall be disclosed by intermediaries, State agencies, or any other organization, institution, or person engaged in performing program functions, only after the request for disclosure has been specifically approved by the Social Security Administration.

6454. ADMINISTRATIVE RULES RESTRICTING DISCLOSURE OF INFORMATION
Manuals prepared for the use of organizations performing functions under contract with the Administration, staff instructions, interoffice correspondence, and other memoranda and materials relating to internal operating procedures are confidential and not to be disclosed to the public. This restriction is based upon administrative decision and is in conformance with the applicable rules and requirements of the Administrative Procedure Act.

6456. AUTHORITY FOR REFUSAL TO DISCLOSE INFORMATION
When a request for information is received, disclosure of which is prohibited under the preceding sections, it is to be declined on the basis of the provisions of section 1106(a) of the Social Security Act, as amended, and Regulation No. 1 of the Social Security Administration (20 CFR 401). If any person, or an officer or employee of any organization, institution, etc., described in the preceding section, is served with a subpoena or other compulsory process requiring the production of records or information the disclosure of which is prohibited, he will decline to produce the records or information, basing his refusal on section 1106 of the Social Security Act and Regulation No. 1 of the Social Security Administration (20 CFR 401). If a subpoena is served on an officer or employee of any organization described above or any other person who is prohibited by section 1106 from disclosing the requested information, the Regional Representative, Health Insurance, is to be notified immediately.

6458. FAILURE TO COMPLY WITH THE RULES RELATING TO DISCLOSURE OF INFORMATION OBTAINED IN THE ADMINISTRATION OF THE ACT

Section 1106(a) of the Act provides that any person who violates the disclosure provisions shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding 1 year, or both.

Review and Hearing

6480. THE HEARING PROCESS

An individual enrolled under the medical insurance program is to be provided with a fair hearing by the carrier when he is dissatisfied with the carrier's determination denying a request for payment or with the amount of the payment under Part B, or when he believes that the request for payment is not being acted upon with reasonable promptness. A physician or supplier, as assignee of the enrollee, is also entitled to a fair hearing on the same grounds as those afforded the enrollee. An enrollee who assigns his claim for payment for Part B services does not lose his right to a fair hearing. He retains his right to question the reasonableness of the charge established by the carrier since this determination affects the amount for which he is responsible under the coinsurance requirement of the medical insurance plan. The law does not provide for any appeal to the Social Security Administration from the carrier's decision or for judicial review of the "fair hearing" decision.

A number of governing principles have been established to serve as guidelines for carriers to assure that a claimant under Part B will receive a fair hearing. In view of the variation in the type of organizations which qualify as carriers under Part B, it is desirable that the Administration provide general guidance as to its requirements for a fair hearing, setting only the irreducible minimum of procedures and formal requirements, and permitting the carrier to operate with as much latitude as possible. Though each carrier will establish its own methods for providing a fair hearing, the Administration will spot review "fair hearing" decisions to assure that the methods and procedures employed are, in fact, consistent with the governing principles for a fair hearing set by the Administration. Through this nonadjudicative survey of decisions, the Administration will be in a position to advise and consult with carriers, to assist them in maintaining quality determinations, and assure that claimants receive a fair hearing. The Administration will give every assistance to carriers to help them set up the fair hearing procedure.

6482. INFORMAL REVIEW

Carriers will institute an informal review procedure as a prerequisite to the fair hearing. An informal review procedure, which is a less costly and a more expeditious device for handling complaints than a formal hearing, is particularly appropriate for handling benefit determination complaints arising under Part B, since relatively small amounts of money will be involved in most cases. Most, if not all, carriers have experience with some type of informal procedure for handling complaints and the Administration

expects that they will, therefore, have no difficulty in adapting to the informal review which is to be provided under the medical insurance program.

A claimant must be notified in writing, at the time a carrier makes a determination with respect to a request for payment for Part B services furnished the enrollee, of his right to question the carrier's decision and the time limit, if any, within which the review must be requested. The claimant must be promptly advised of the decision resulting from the informal review, of his right to request a fair hearing if he is not satisfied with the review determination, and the time limit, if one has been established, within which the hearing is to be requested.

6482.1 Elements of Informal Review.--The following represents the essential elements necessary to an adequate informal review.

A. Notice of the right to question an adverse decision of the carrier should be provided to the claimant at the time the carrier acts on a request for payment. The notice of the claims action should contain an appeals paragraph such as the following. "If you have any question with regard to the action taken on this claim, please write to (___carrier___.)" The claimant may also be referred to the local district office for assistance in writing out his complaint. The district office staff will give the claimant general program information, and if he wishes to request a review of the decision, will help to phrase his complaint; however, they will not give any opinions as to the decision made in the particular claim.

B. Provision should be made for the informal review of disputed claims in the claims processing unit of the carrier; however, an individual other than the one who made or participated in making the initial determination should perform the review.

C. The purpose of the informal review is to provide a new, independent, and critical review of the claim. The reviewer should not be influenced by the initial determination, but should, instead, review each aspect of the claim independently and arrive at his own conclusions. He should review not only the point at issue, but the entire claim bearing in mind that the carrier is on notice of a dispute.

D. The claimant is to be given an opportunity to submit any relevant and material evidence. The reviewer should request

additional evidence from the claimant and/or the physician, provider or other supplier of services if he finds it necessary. The claimant is to be instructed to submit evidence and statements in writing by mail or through his local Social Security Administration District Office. Since one of the purposes of instituting the informal review is to cut down unnecessary costs, the review will not provide for personal appearance and testimony by the claimant and face-to-face contact with the claimant at this stage in the claim process should be discouraged. If personal contacts are necessary, they should be made by Social Security Administration District Office personnel.

E. The claimant is to be sent notice of the review determination setting out the bases for the determination. He is also to be notified of his right to a fair hearing if the review determination is an adverse one.

F. All carrier actions in the review of a claim are to be fully documented and the file should include all correspondence, papers, requests, reports, etc., arising out of the claims review process. This file will be necessary for the conduct of the fair hearing, if requested. The carrier is to make the file available to the Social Security Administration, if so requested.

6485. **THE FAIR HEARING**

The fundamental purpose of a fair hearing is to provide an individual, dissatisfied with what he considers to be an adverse decision on his claim for payment, an opportunity to present the reasons for his grievance and to afford him an impartial review based on the substance of his claim.

The principles enumerated below are to be applied by the carrier in setting up the fair hearing required under section 1842 of the Act to handle complaints by individuals dissatisfied with the informal review determination.

6485.1 Notice of Right to a Hearing.--The notice of an adverse informal review decision must give the individual notice of the right to a fair hearing, the place and manner of requesting the hearing, and, if any, the time limit for requesting it.

To provide a claimant a reasonable period of time in which to request a hearing, a period of at least 6 months after the notice of informal review must be allowed in which the individual can register a protest. A request for a hearing is any clear expression by the claimant (or by a person acting on his behalf) to the

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effect that he is dissatisfied with the carrier's determination regarding his claim for Part B benefits and wants an opportunity to present the matter to a higher authority.

6485.2 Notice of Time and Place of Hearing.--A claimant who requests a fair hearing must be given adequate written notice of the time and place set for the hearing, information as to the specific issues to be determined and the matters on which findings will be made and conclusions will be reached. The notice will be given as promptly as possible after receipt of the request for a hearing. Where the hearing was requested by a person on behalf of the claimant, notice must also be given to that person.

Consistent with the public interest and efficient execution of the program duties of the carrier, the hearing is to be scheduled for a time and at a place convenient to the claimant and his representative, if any. The notice of the hearing is to be given sufficiently in advance of the date set and is to contain sufficient information about the hearings procedure (including the claimant's right to representation) for effective preparation for the hearing.

A request for a hearing may be withdrawn only by the claimant or his authorized representative and the withdrawal must be in writing. A request for a hearing may be considered abandoned if neither the enrollee nor his representative appears at the time and place set for the hearing and no reply is received within a reasonable time (10 days) to a notice of inquiry mailed to the enrollee and his representative.

6485.3 Hearing Officer.--The hearing is to be conducted by a competent, qualified and impartial individual. The hearing officer is to be an individual who has not been involved in any way with the determination in question and has neither advised nor given consultation on the enrollee's request for payment which is the basis for the hearing. The hearing officer should be an attorney or other qualified individual with ability to conduct formal hearings and with some understanding of medical matters and terminology, and a thorough knowledge of the program and the regulations issued thereunder.

6485.4 Hearing Procedures.--The hearing procedure must provide an opportunity for the enrollee to appear in person and, if he desires, to be represented by legal counsel or by any other qualified individual. The claimant may, however, forego the opportunity to appeal personally or through a representative. A claimant and/or his representative must have the opportunity to offer oral and written evidence, to examine and reply to evidence relied upon by

the carrier as the basis for its action, and to present and examine witnesses. The rules of evidence established for the hearing procedure must offer sufficient latitude so that all relevant and material evidence can be accepted and considered without regard to whether it would be admissible under the rules of evidence applicable to court procedures.

6485.5 Hearing Decision.--The hearing officer must base his decision on the record, that is, the stenographic record of the hearing, documents, requests, papers and other written evidence. The record is to be made available to the claimant or his representative for examination. If the claimant wishes to have a transcript of the stenographic record, it shall be made available to him if he pays the cost of preparation. Written notice of the hearing officer's decision and the basis for the decision must be furnished the claimant as promptly as possible after the close of the hearing.

6485.6 Issues for Determination at a Fair Hearing.--The "fair hearing" procedures are to be utilized only to settle a controversy involving benefits under Part B and not to resolve any other issues which may arise. For example, specific issues to be considered at the fair hearing may relate to such factors as the reasonableness of physician charges, whether items and services furnished are covered; whether the deductible has been met; whether the receipted bill or other evidence of payments is acceptable, etc. The carrier may not make determinations as to an individual's basic entitlement under the supplementary medical plan; or whether an independent laboratory furnishing services meets the conditions for coverage of services.

Intermediaries should institute procedures to assure that appropriate disposition is made of all protests and complaints. If a carrier receives a protest from a claimant concerning an issue which is outside of the carrier's area of responsibility, it should be forwarded to the Administration without delay and the claimant advised of the referral. Where a complaint is received by the carrier which encompasses more than one issue, some of which are outside of the carrier's area of responsibility, the complaint should be referred to the Administration for consideration of those aspects of the protest over which the carrier has no jurisdiction. However, the carrier should proceed with the review of that portion of the protest which falls within the confines of its adjudicative duties, provided that a decision on such portion of the complaint is not dependent on the Administration's determination on the other issues. Where such dependency exists, the carrier will defer its review pending the Administration's decision on the other issues.

CHAPTER VI

REPORTS AND STATISTICS

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6500. OBJECTIVES OF STATISTICAL PROGRAM

The Health Insurance Program for the Aged will have a great impact on the organization and financing of medical care services in this country, on the number and kinds of health care facilities and personnel, and on the amount and kinds of health services utilized by the aged as well as by other age groups. At the same time, the program will offer a means for obtaining complete, systematic, and continuous information about the amount, kind, and cost of health care services used by the aged as a by-product of benefit payment operations.

The need for statistics about the impact of the program and its operation are expressly recognized in Public Law 89-97, "The Health Insurance for the Aged Act." Section 1875(b) expressly directs that,

> "The Secretary shall make a continuing study of the operations and administration of the insurance programs under parts A and B and shall transmit to the Congress annually a report concerning the operation of such programs."

The statistical program has, therefore, been designed primarily to provide basic data on program operations on a recurrent basis.

In addition, the statistical program is designed to provide the basis for a variety of special analyses and analytical studies to evaluate the program and measure its performance. The Administration, the Congress, and many outside groups will be concerned with assessment of program operation and achievements in terms of the goals of the program to protect the aged person against the catastrophic costs of hospitalization and illness and to provide quality hospital and medical care in the most efficient and economical manner. Statistics will also be collected to analyze and compare the operations of intermediaries with respect to the effective and efficient operation of the program.

6502. HOW STATISTICS WILL BE COLLECTED

All basic, recurrent program statistics will be collected and compiled centrally by the Social Security Administration. Intermediaries will not be required nor expected to tabulate and prepare routine statistical reports.

Basic program statistics will be compiled by the Administration from a continuous sample of bills (Request for Payment and Provider Billing for Patient Services by Physicians and receipted bills from physicians and other medical suppliers) that intermediaries will send to Baltimore. Specifications for selection of the sample are

given in § 6505 below. In order to keep to a minimum the number of bills in the continuous sample, the Administration will use information contained in payment records, which intermediaries will furnish for all cases reimbursed under the program, to supplement the information in the continuous sample of bills. Information in the payment record will be used to select samples of cases for special studies. Such studies will be necessary to supply detailed information about aspects of the program, which cannot be derived from the continuous sample of bills because it is a small sample. Payment records will be used to identify bills required for special studies. Intermediaries will be asked to furnish copies of these bills, as identified by the Administration, for these special ad hoc studies, as required.

Intermediaries will be required to prepare only one repetitive statistical report. This will be a summary report, prepared and submitted monthly, which will contain gross figures on intermediary workloads, including counts of bills received, processed, and pending. (See § § 6540ff. for a sample copy of the report and instructions for its preparation.)

Continuous Sample of Billing Forms

6505. SELECTION OF SAMPLE BILLS AND BILLING FORMS
Intermediaries will send to Baltimore one copy of each bill, request for payment, or other billing form, along with a copy of all related worksheets, for all beneficiaries whose health insurance claim numbers end with the digits specified below.

A. For a 9-digit numeric health insurance claim number followed by a 1, 2, or 3 position alpha-numeric suffix (the first digit of the suffix must be alpha), the sample digits are in the eighth and ninth position of the all numeric first nine digits. All HI claim numbers with the following combination of digits in the 8th and 9th position will fall in the sample regardless of the suffix: 05, 20, 45, 70, 95.

Examples:

XXX XX XX05A in sample
XXX XX XX20B in sample
XXX XX XX95D1 in sample
XXX XX XX40A not in sample
etc.

B. For a 6-digit numeric health insurance claim number preceded by a 1, 2, or 3 position all alpha prefix, the sample digits are the fifth and sixth position of the numeric portion of the number. All health insurance claim numbers with the following combinations in these positions will fall in the sample regardless of the prefix: 05, 20, 45, 70, 95.

Examples:

A	XXXX05 in sample
MA	XXXX70 in sample
WCD	XXXX45 in sample
WA	XXXX90 not in sample
etc.	

C. For a 9-digit numeric health insurance claim number preceded by a 1, 2, or 3 position all alpha prefix, the sample digits are the eighth and ninth position of the numeric portion of the number. All health insurance claim numbers with the following combinations in these positions will fall in the sample regardless of the prefix: 05, 20, 45, 70, 95.

Examples:

A	XXX-XX-XX05 in sample
MA	XXX-XX-XX95 in sample
WA	XXX-XX-XX20 in sample
WCD	XXX-XX-XX75 not in sample
etc.	

This selection is designed to yield a 5 percent sample of all Request for Payment and Provider Billing for Patient Services by Physicians forms to be sent to SSA. However, forms with health insurance claim numbers falling into the sample should not be sent to Baltimore until the $50 deductible for the year is met. Thus, the first bill to be copied and sent to SSA as part of the continuous sample is the first one received during the year that requires reimbursement. After the first sample bill is sent to Baltimore copies of all subsequent bills for individuals falling into the sample will be sent to Baltimore routinely. At the time the first sample bill for a particular individual is sent to Baltimore, the intermediary will also send in copies of the bills, if any, for that individual that were used by that beneficiary to satisfy his $50 deductible. Bills for noncovered services should not be included in the sample.

6510. MATERIAL TO BE SENT TO BALTIMORE FOR EACH CLAIM FALLING INTO CONTINUOUS SAMPLE OF BILLS

For each bill falling into the continuous bills sample, intermediaries will send to Baltimore a copy of the billing form or request for payment, a copy of all receipted bills and/or statements from physicians and other medical suppliers that may be attached to the billing form or request for payment, a copy of any additional explanatory or developmental information obtained from the physician and/or supplier, and a copy of any worksheets that the intermediary uses in processing claims. It is not anticipated that every request for payment or other billing form sent to SSA as part of the continuous bill sample will have additional material attached to it. However, if the physician is recontacted about a specific bill to obtain additional details about treatment or services provided, a copy of the additional information obtained should be attached to the copy of the request for payment--unless the additional information is entered directly on the request for payment or billing form. Similarly, a copy of the computation worksheet, or a machine print-out if benefit computation is done by computer should be attached to the sample bill only if itemized reasonable charges and total reimbursement amount are not shown on the request for payment or other billing forms. For example, if the intermediary enters on the request for payment or other billing form his determination of reasonable charges, making a separate entry for each charge itemized on the billing form, and also enters the total amount of reimbursement for the bill, a copy of the computation worksheet or computer print-out need not be attached. On the other hand copies of worksheets or computer print-outs should be attached if itemized reasonable charges are not entered manually on the request for payment or other billing forms. Some intermediaries may find that the simplest way to supply the information desired on reasonable charges and total reimbursement amounts is by attaching a copy of the "Explanation of Benefits" sent to the beneficiary to the continuous sample bill.

A clear legible copy of all forms in the sample must be sent to SSA. Where individual bills must be reproduced, a high quality reproduction is essential. Copies of all receipted bills, worksheets, etc., that are being transmitted should be firmly attached to the billing form or request for payment to which they relate. The point at which billing forms are selected for the continuous sample and sent to Baltimore will probably vary from intermediary to intermediary depending on their method of operation. However, billing forms should be selected for the

sample only after they have been processed and determinations made of reasonable charges and reimbursement amounts due. Nevertheless, sample forms should be selected and sent to Baltimore at the earliest point possible after claims processing and acceptance for payment. On all copies of requests for payment and of bills to be sent to SSA as part of the continuous bill sample, the physician's name (or the name of the supplier of other medical services), his address, and his signature should be masked out in the copying process. Be sure not to mask out the physician's number or the specialty code.

6515. VERIFICATION OF SAMPLE SELECTION

Since requests for payment and other billing forms to be sent to the Social Security Administration are a sample from which universe projections and estimates must be made, it is imperative that the selection be accurate. Therefore, intermediaries should assure that--

a. All sample cases but only sample cases are selected;
b. Cases where the deductible has not been met and no reimbursement is involved are not sent;
c. If the sample bill is the first claim above the deductible for which reimbursement can be made, then all prior claims within the deductible are sent.

The procedure for how this is done will depend again on each individual carrier's system of operations.

6517. ACCURACY AND COMPLETENESS OF SAMPLE FORMS

As a general rule, requests for payment, other billing forms, and receipted bills submitted by physicians and other medical suppliers or by beneficiaries, that contain enough information, and in sufficient detail, to permit intermediaries to make determinations of reasonable charges will contain enough information to satisfy statistical needs.

Sample forms sent to the Social Security Administration should be accurately prepared and completed. For sample cases where Part II of the request for payment form has not been completed and receipted bills are attached, the attached bills should show the same information that would appear in Part II of the request for payment. Information on the request for payment and other billing forms should be shown in such detail as to permit the Social Security Administration to relate date and place of each service to the services or procedures furnished, to the condition being treated, and to the total and reasonable charges involved. Procedures and services should be described specifically and in detail.

In cases where two or more services (e.g., surgery and X-ray) are entered on a billing form the above information as it relates to each service should be clearly specified on the form, e.g., combined charges for separate services rendered to a beneficiary by a physician are not adequate. A range of dates for two or more services (e.g., Jan. 1-10) should also be avoided. The date of each service is needed.

It is realized that when a patient submits individual receipted bills along with the Request for Payment form, diagnosis will often not be shown in accurate medical detail for many cases, and that other items may not be as complete as is required in Part II of the Request for Payment form. In these situations any additional or clarifying information obtained by the intermediary to determine reasonable charges should be entered on the Request for Payment form, or other billing form, or on case development sheets. In instances where the physician submits itemized or machine prepared bills similar annotations should be made.

Where Part II of the Request for Payment is completed, enter in the column labeled "Leave Blank" your determination of reasonable charges for each line entry. Enter the proper money amount. Enter the reasonable charge figure alongside the related total charge entry. Where Part II of the Request for Payment is not completed and receipted physicians' bills are attached instead, enter the amount of reasonable charges on each receipted bill. Show on each individual bill the amount of the reasonable charges for that bill. Where reasonable charge figures are itemized on computation worksheets, on computer print-outs, or on notices of payment sent to beneficiaries they need not be entered on the request for payment or other billing forms. However, all reasonable charge amounts should be clearly labeled on computer print-outs, computation worksheets, etc., so that they can be related to the specific services involved.

6520. CODING OF BILLING FORMS INCLUDED IN CONTINUOUS SAMPLE
Generally, intermediaries will not be required to code procedures or diagnoses on requests for payment or other bills that they receive for payment and that are part of the continuous bill sample. Some intermediaries may enter detailed procedure codes and diagnostic codes on requests for payment and other billing forms as part of their routine claims process. Intermediaries that do such coding should leave the codes on the copies of the billing forms sent to SSA.

6520.1 Coding Physician Specialty.--On each request for payment or other billing form falling into the continuous bill sample, intermediaries will code, on each bill involving physicians' services, the specialty of the physician rendering the service being reimbursed. The code should be entered next to the physician's signature. In non-assignment cases--where receipted bills are attached to the Request for Payment enter the code on the billhead alongside the physician's name. The 2-digit codes to be used are:

Code	Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB - Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation

Code	Specialization
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
49	Miscellaneous
99	Unknown
NA (Not available)	To be used only until January 1, 1967

Physician specialty should be coded beginning July 1, 1966 if possible. Intermediaries who do not have the necessary information and are, therefore, unable to code this item on July 1, 1966 should begin coding it as soon thereafter as possible and in no event later than January 1, 1967. Information on physician specialty is available from directories issued by the American Medical Association and State and local medical societies. Individual physicians will be considered specialists if they consider themselves specialists and so classify themselves regardless of whether or not they are certified by specialty boards.

6520.2 Coding Type of Supplier.--Bills involving services provided by suppliers other than physicians should be coded with a type of supplier code next to the supplier's signature. The codes to be used are:

Code	Type of Supplier
51	Medical supply company with C.O. (Certified orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist-certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with C.P.O. (Certified prosthetist-orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification

Code	Type of Supplier
54	Medical supply company not included in 51, 52, or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individual not included in 55, 56 or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State, Local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
69	All other, e.g., Drug and Department Stores (Trusses)
88	Unknown
NA (Not available)	To be used only until January 1, 1967

Type of supplier should be coded beginning July 1, 1966 if possible. Intermediaries who cannot code this item at that time because they lack the necessary information should begin coding it as soon thereafter as possible and in no event later than January 1, 1967.

6520.3 Coding Dates of Receipt and Approval.--Enter in the top margin of each form in the center of the form the date the billing form was received in your office. In the bottom margin of the form in the center enter the date the bill was approved by you for payment. Dates should be entered numerically showing month (2 digits), day (2 digits), and last position of year (1 digit). For example, November 25, 1966 would be entered 11-25-6. Date of approval should not be entered on bills covering services for which no reimbursement is made (deductible not satisfied). Where these dates are shown (and clearly identified) on computation worksheets or computer print-outs that are attached to copies of the billing forms, they need not be coded on the billing form itself.

6522. SENDING CONTINUOUS SAMPLE FORMS TO SOCIAL SECURITY ADMINISTRATION

All sample forms should be sent to the Social Security Administration on a daily basis or a minimum of 3 times weekly. Before shipment each of the sample forms (and any attachments) should have the intermediary number assigned for use in the social security health insurance program entered in the upper left corner of the form. See Chapter for instructions dealing with transmittal of sample forms to SSA.

Reports of Payment of Individual Claims (Payment Records)

6524. PURPOSE OF PAYMENT RECORDS

Intermediaries will prepare, and send to SSA, a Payment Record for every bill for which reimbursement is made under the supplementary medical insurance program. The Payment Record will have very important administrative and statistical uses. Some of the more important uses of the Payment Record are--

a. To provide information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of cost estimates and operating statistics.

b. To provide information to assist in the conduct of administrative and fiscal audits of intermediary operations.

c. To enable SSA to determine whether the forms that intermediaries will be sending SSA as part of the Bill Sample are actually a representative sample of all bills--to determine, for example, whether we are getting all billing forms that we should, whether items in the sample are being given special handling, etc.

d. To enable SSA to draw samples for special ad hoc studies focusing on specific groups of doctors, costly procedures, or on specific types of services.

6526. WHEN TO PREPARE A PAYMENT RECORD

A Payment Record should be prepared after the amount of reimbursement on an individual bill has been determined and payment is being made. Intermediaries will be responsible for determining the best way to integrate preparation of the Payment Record with their bill review and payment operation to assure accurate and timely Payment Records. A payment record should be submitted for every bill for which reimbursement is made. Situations will arise--e.g., overpayments, partial payments, incomplete information--where intermediaries will

determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record should be submitted using the proper debit-credit code shown in § 6532 below. If the bill is one that is part of the continuous bill sample, a new copy of the bill should be submitted marked "Corrected" at the top.

Payment records should be prepared on an individual beneficiary--individual physician (or supplier)--individual "bill" basis. A "bill" will be defined as a request for payment from a beneficiary accompanied by one or more receipted statements from a single physician or single supplier. A request for payment from a beneficiary accompanied by receipted statements from two or more different physicians will be considered as two or more separate bills. A Request for Payment from a physician for services rendered a single beneficiary will be considered a single bill regardless of the number of visits or services contained on the request. On the other hand requests for payment from a physician for services rendered three beneficiaries will be considered as three bills even if the physician sends them to the intermediary in a single batch.

The definition of a Payment Record is the same as that of a bill except that no payment record will be prepared for bills for which no reimbursement is made under the supplementary medical insurance program. For example, a request for payment from a beneficiary accompanied by one or more receipted statements from the same physician would require preparation of one payment record (assuming the deductible is met). On the other hand, if a beneficiary (once having met the deductible) cumulates bills and submits bills from two physicians for medical treatment and from an orthotist for fitting and purchase of an artificial leg, the intermediary will prepare three Payment Records--one for each physician's bill and one for the bill from the orthotist. Separate payment records will be prepared whenever a request for payment is submitted containing services rendered in different calendar years for which the deductible has been met.

6528. PREPARATION OF PAYMENT RECORDS FOR BILLS FOR HOSPITAL-BASED PHYSICIANS

These definitions and instructions will also apply generally to the preparation of payment records for physicians who bill through a hospital, extended care facility, or home health agency, using Form SSA-1554, Provider Billing for Patient Services by Physicians. Where the deductible has previously been met, one payment record will be prepared for each physician whose services are reported

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on the form. For example, if a hospital submits a bill for a patient covering the services of a radiologist, anesthesiologist, and a pathologist, three Payment Records will be prepared--one for each of the physicians involved.

Where the deductible has not previously been met but some reimbursement is to be made to the hospital the number of payment records to be prepared will vary depending on the number of physicians included on the billing form, the total reasonable charges for each physician, and the amount to be charged off against the remaining outstanding deductible. Either of two methods will be acceptable to SSA.

A. The reasonable charges for the physician with the lowest combined reasonable charges on the billing form will be credited against the deductible first, followed by the reasonable charges for the physician with the next lowest combined reasonable charge, and so on until the deductible is satisfied. A payment record should then be prepared for each physician whose total reasonable charge on the billing form has not been fully credited against the deductible. The example below illustrates the procedure.

 Assume receipt of a billing form for hospital-based physicians services showing the following (hypothetical) reasonable charges.

Physician	Date	Reasonable Charge	Deductible Credited	Reimbursement Amount	Payment Record
Radiologist A	7/6	$40	$20	$16	Yes
Anesthesiologist B	7/9	$10	$10	--	No
Pathologist C	7/11	$5	$5	--	No
Anesthesiologist B	7/15	$10	$10	--	No
Pathologist C	7/16	$5	$5	--	No

 Assume also that this is the first bill received for the beneficiary involved. Using the procedure outlined above, all of the charges made by the pathologist (combined reasonable charges = $10), all of the anesthesiologist's reasonable charges (combined reasonable charges = $20), and $20 of the radiologist's reasonable charges--a total of $50--would be credited against the deductible. The amount of reimbursement would be computed as 80 percent of the $20 of the radiologist's charges not credited against the deductible. Only one payment record would be prepared--that for the radiologist. The Payment Record would show reasonable charges of $40, a reimbursement amount of

$16, and $20 as credited against the deductible. Of course, in any situation where no reimbursement is to be made to the hospital, these procedures would not be applicable and no payment record will be prepared.

B. Alternatively, the reasonable charges for the physician with the largest combined reasonable charge reported on the billing form should be credited against the deductible first, followed by the charges for the physician with the next largest combined reasonable charge, and so on. Thus, this alternative would work in the same way as that described in "a" above but in reverse.

In the example given above, two payment records would be required--one relating to the anesthesiologist's service and one to the pathologist's service--since satisfaction of the deductible would require crediting of the radiologist's charges in full ($40) but only $10 of the anesthesiologist's charges of $20.

All intermediaries should follow either of the alternative procedures described above in preparing payment records for bills for hospital-based physicians. The first procedure described--crediting of the smallest charge against the deductible first--is preferred by SSA since that procedure will operate to reduce the number of Payment Records that intermediaries will have to prepare.

6530. PREPARATION OF PAYMENT RECORDS FOR NONASSIGNMENT CASES

The rules described in the preceding section for the preparation of payment records for bills for hospital-based physicians should also be used in preparing payment records for nonassignment cases where the beneficiary submits bills from two or more physicians (or suppliers) at the same time.

6532. CONTENT OF THE PAYMENT RECORDS

The preparation of payment records is effective July 1, 1966. SSA anticipates that all intermediaries will conform to the same data record format. Reporting may be done by punch card or magnetic tape. For the record layout, follow the guides below and in exhibit 1.

Number of Columns	Item	Description
(12)	HI Claim Number	The beneficiary's health insurance claim number

Number of Columns	Item	Description
(11)	Surname	Beneficiary's surname - left justified with blanks in unused columns
(2)	Initials	Beneficiary's first and middle initial (blank in unused columns)
(1)	Debit-Credit Code	A code signifying disposition: 1-original debit 2-new debit 3-full credit 4-void credit Code "3" removes the original and code "2" replaces the debit. Code "4" removes the original with no replacement.
(1)	Expense Year	Unit position of the year in which expenses were incurred as shown on the Request for Payment.
(1)	First Expense Month	The month of the earliest incurred expense shown on the Request for Payment. Use digits 1-9 for January-September. Use zero (0) for October, minus (-) for November, and plus (+) for December.
(1)	Last Expense Month	The month of the most recent incurred expense shown on the Request for Payment. Repeat first expense month if all expenses incurred in the same month. Use the same codes as specified for the first month of expense.
(6)	Reasonable Medical Charges (Non-Psychiatric)	The reasonable charges for the non-psychiatric items on the Request for Payment form for which payment has been made.

Number of Columns	Item	Description
(5)	Outpatient Psychiatric Expense	The outpatient psychiatric expense represents 62½% or $312.50 (whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment form for which payments have been made.
(4)	Deductible Applied	Amount of the incurred expenses (medical and/or psychiatric) in this record which were applied to the deductible.
(6)	Reimbursement Amount	The amount of payment made to or on behalf of the beneficiary.

NOTE:

	Reasonable Medical Charges
Plus	Psychiatric Expense
Less	Deductible Applied
Multiplied	by 80%
Equals	Reimbursement Amount

(8)	Intermediary Control Number	The control number assigned by the intermediary to the individual bill. SSA may use this number for case identification in correspondence, etc., with the intermediary.
(1)	Type of Physician & Board Certification	A code showing whether the physician is an M.D., DO, DDS, or DMD and whether he is certified by a specialty Board. This information is available from directories issued by the American Medical Association and State and local medical societies. Code as follows: "1" for MD - Board certified "2" for MD - not Board certified "3" for MD - Board certification not known "4" for DO - Board certified "5" for DO - not Board certified "6" for DO - Board certification not known

Number of Columns	Item	Description
		"7" for DDS/DMD - Board certified "8" for DDS/DMD - not Board certified "9" for DDS/DMD - Board certification not known "0" for bills not involving physicians' services
(9)	Physician or Supplier Code	The number that the intermediary uses to identify each individual physician or medical supplier (ambulance service, clinical laboratory, medical supply house, etc.). Intermediaries may use the numbers that are currently in use. These numbers may be license numbers, tax numbers, social security numbers, or simple serial numbers. Only one number should be used for an individual physician or supplier in connection with the HIB program.
(3)	Largest Single Reasonable Charge	Amount of money rounded to the nearest dollar for the item of service on the bill which is determined to have the largest reasonable charge. For bills showing only one service, the amount would be the charge for that service. For bills showing several services with the same reasonable charge for each, enter here the charge for the first service shown on the bill. If greater than $999, show as 999.
(1)	Place of Service	Show here the place where the service having the largest single reasonable charge (as identified in the item above) was rendered, using the following classification: Code as follows: "1" - Office "2" - Home "3" - Inpatient Hospital "4" - Extended Care Facility

Number of Columns	Item	Description
		"5" - Outpatient Hospital "6" - Independent Laboratory "7" - Other
(1)	Type of Service	Show here the type of service having the largest single reasonable charge (as identified above), using the following code: "1" - Medical Care "2" - Surgery "3" - Consultation "4" - Diagnostic X-ray "5" - Diagnostic Laboratory "6" - Radiation Therapy "7" - Anesthesia "8" - Assistance at Surgery "9" - Other medical service The following definitions of type of service will be used in assigning the codes listed above: 1. Medical Care - Includes all physician services, not elsewhere classified, and covers office visits, home visits, nursing home visits and non-surgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded. 2. Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and covers services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy.

Number of Columns	Item	Description

3. Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient.

4. Diagnostic X-ray - X-ray and related services undertaken for diagnostic purposes.

5. Diagnostic Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.

6. Radiation Therapy - Therapeutic services, such as X-ray, radon, radium and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, mangiomas, vascular nevi, lymphomas, leukemia and thyroid disease.

7. Anesthesia - Services for anesthesia include the appropriate pre- and post- operative visits, administration of anesthestic, and transfusion of fluids and/or blood incident to the anesthesia or surgery.

8. Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such service prescribed by the intermediary.

Number of Columns	Item	Description
		9. Other Medical Services - Services falling in the following special categories: ▪ rental of durable medical equipment ▪ ambulance service ▪ internal and external prosthetic devices and appliances ▪ supplies
(1)	Number of Separate Itemized Charges	A count of the number of separate charges shown on the request for payment or on the other billing forms (including receipted bills) to which the specific Payment Record relates. Use "9" for 9 or more.
(1)	Employment Relationship	A code showing whether or not the illness or injury requiring treatment was related to the beneficiary's employment. Use the information supplied by the beneficiary on the Request for Payment Form SSA-1490. Code as follows: "1" for "yes" (connected with employment) "2" for "no" (not connected with employment) "3" for information not available
(1)	Number of Dates of Service	The number of separate dates of service incurred listed on the bill attachment or on the request for payment. (Where the count of these items is over 9, show "9.")
(1)	Payment Code	A code showing whether the payment being recorded was made to the beneficiary, to the physician or

Number of Columns	Item	Description
		supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill) or to a provider where the provider bills for physician. Code as follows: "1" for payment to physician or supplier "2" for payment to beneficiary "3" for partial payment to both "4" for payment to provider (hospital-based physicians) "5" for partial payment to both provider and beneficiary "6" for payment to group practice prepayment plan "7" for payment to other entities
(2)	Physician or Supplier Specialty	A two-digit code for each physician or supplier of other medical services dealing with the intermediary, showing the physician's specialty or the type of supplier. The same codes as shown in §§ 6520.1 and 6520.2 of this chapter will be used.

Some intermediaries may not be able to provide information about: (1) Board Certification and (2) Physician or Supplier Specialty on July 1, 1966 because they do not have the necessary information. Both items should be added to the payment record as soon as possible after July 1, 1966 and in no event later than January 1, 1967. Intermediaries should notify the SSA as to when they plan to add these two items to the payment record, if they will not be doing so on July 1, 1966.

Preparing Payment Records Prior to Transmission to SSA

6534. BATCHING PAYMENT RECORDS

It is suggested that punchcard reporting intermediaries group payment records in batches of 2,000 when preparing to transmit them to SSA. When reporting is made by magnetic tape, the entire tape may be one batch or there may be more than one batch on a tape. Where more than one batch is submitted on a tape, a header

record must precede each batch; a batch control record must be the last record of each batch; a tape mark must follow the batch control record; a header for the next batch must follow the tape mark; etc. The last tape mark following the last batch control record on tape must be followed by an end-of-file trailer and a tape mark. (See Chapter VII for transmittal of batches.)

6536. BATCH CONTROL TOTAL RECORD
For each batch, whether punchcard or magnetic tape, the intermediary prepares a batch control total record including at least the data specified below. (See exhibit 1 for the record layout of the batch control total record, and exhibit 2 for magnetic tape report of payment input header and trailer format.)

Number of Columns	Numbered	
5	1-5	Intermediary Number. SSA has assigned this number to the intermediary submitting the payment records.
5	6-10	Batch Number. The carrier assigns this number to identify the batch. The number should consist of the last digit of the year, two digits for the month (such as 01 for January and 12 for December), and a two-position sequence number. The sequence number will be from 01 through 99 for any given month. Normal debits and adjustment debits and credits will be submitted in the same batch. The first batch sequence number of a new month must be 01.
1	11	Record Indicator. (+ or 12 punch) Used to identify this as a "Batch Control Total Record."
5	12-16	Batch Count. This is the number of payment records included in the batch.

NOTE: The money totals of the payment records included in the batch must balance with the money totals specified in the related fields shown below.

Number of Columns	Numbered	
9	17-25	Reasonable Medical Charges for Other than Psychiatric Care. Show the net total amount of medical charges used as the basis for reimbursement from all payment records included in the batch.
9	26-34	Reasonable Charges for Noninpatient Psychiatric Care. Show the net total amount of noninpatient psychiatric expenses used as the basis for reimbursement from all payment records in the batch. (Use the 62.5 percent figure.)
9	35-43	Deductible Applied. Show the net total expenses reported in the payment record batch that were applied toward deductibles for the beneficiaries.
9	44-52	Reimbursement Amount. Show the net total amount reported in the batch of payment records that was reimbursed to or on behalf of the beneficiaries.
1	80	Record Mark. ≠

Monthly Statistical Report on Status of Intermediary Workloads

6540. CARRIER WORKLOAD REPORT (FORM SSA-1565)--GENERAL
Each intermediary will prepare and submit to the Social Security Administration a short report each month showing the status of its workloads under the supplementary medical insurance program. A separate report is to be completed for each intermediary office that has been assigned an intermediary number. However, when an intermediary's area covers more than one State a separate report should be prepared for each State.

The purpose of the report is to provide information, quickly and in summary fashion, on the number of SMI bills received and processed each month, and the number pending at the end of each month. This information is needed for administrative and operating purposes. The report will also measure the progress of intermediaries in paying claims for reimbursement for physicians' and suppliers' services

under the health insurance program. The report will be submitted on Form SSA-1565, Carrier Workload Report. Initial supplies of the Carrier Workload Report forms have been sent to intermediaries. Additional forms may be obtained by writing directly to: Social Security Administration, Office of Research and Statistics, Attention: Health Insurance Statistics Branch, P.O. Box 1433, Baltimore, Maryland 21203. Reports will be prepared monthly in accordance with the instructions that follow.

6540.1 Purpose and Scope.--Form SSA-1565, Carrier Workload Report for the Supplementary Medical Insurance Program, is the principal source for summary information on the current status of operations of the carrier. The information supplied will provide a current profile of the overall operating situation for each carrier.

6540.2 Due Date.--Form SSA-1565 is due in Baltimore as soon as possible after the end of the reporting period, but not later than the tenth of the succeeding month. Airmail should be used by carriers west of the Mississippi River, or in any instance when it would expedite receipt of the report.

6540.3 Number of Copies.--The carrier will submit two copies of the Workload Report each month. Send both copies of the report to: Social Security Administration, Office of Research and Statistics, Attention: Health Insurance Statistics Branch, P.O. Box 1433, Baltimore, Maryland 21203.

6540.4 Heading.--Enter the name and code number of the carrier reporting.

6540.5 Reporting Period.--Prepare the carrier monthly workload report for each calendar month.

6540.6 Definition of a Bill.--A bill will be defined as: (1) A request for payment from a beneficiary accompanied by one or more receipted statements from a single physician or single medical supplier. This will be counted and reported as one bill. (2) A request for payment from a beneficiary or provider (i.e., provider-based physicians) accompanied by receipted statements from two or more different physicians or from two or more medical suppliers, or from a combination of two or more physicians and suppliers will be counted and reported as two or more bills. (3) A request for payment from a physician or medical supplier for services rendered a single beneficiary will be counted as a single bill regardless of the number of visits or services covered by the request.

The definition of a payment record is equivalent to that of a bill except that no payment record will be prepared for bills that do not meet the $50 deductible. If payment can be made on any portion of the bill, a payment record will be prepared for the entire bill.

It should be noted that for bills which cover services in different calendar years for which the deductible has been met, two payment records will be prepared. In this instance, two bills would be counted and reported.

In the case of billing for services by hospital-based physicians for a given patient, a bill should be recorded and counted for each physician appearing on the form.

6540.7 Type of Bill.--Claims for reimbursement for covered services under the supplementary medical insurance program will be received from beneficiaries, physicians or other purveyors of medical services--e.g., independent clinical laboratories, orthotists, ambulance operators, etc. For monthly reporting purposes, it will be sufficient to group and count bills in three broad categories, i.e., (a) bills for physicians' services (including bills submitted by providers for the services of provider-based physicians); (b) bills received from independent laboratories; and (c) bills received for all other medical and health services not elsewhere classified.

6542. COMPLETING ITEMS ON FORM SSA-1565

Item 1. Opening Pending

a. Closing pending end of last month--self-explanatory.

b. Adjustment in pending-If error is found in previous end of month's pending (as a result of inventories, duplicate claims, etc.) the adjustment should be entered here. Entry should be preceded by a plus or minus sign, as appropriate. Explain reason for adjustment in remarks section.

c. Total Opening Pending--Enter here the result of the adjustment to the closing pending.

Item 2. Receipts

a. Bills received this month--Enter here all bills received during the month, including those that have been previously handled.

Include here all bills regardless of whether payment will be made.

This count should be made at the point where bills are normally controlled before going to the claims examiner.

b. Bills transferred out--Record here the number of bills that were transferred to another carrier during the month because beneficiary, physician, provider, or other purveyor of medical services submitted bill to wrong carrier.

c. Bills returned for additional information--Report here the number of bills returned to the beneficiary, physician, provider, or other purveyor of medical service during the month because the form is incorrectly completed, etc.

d. Bills rejected and returned--Report here the number of bills received that are returned to claimant because claim is clearly for services not covered under the law. Do not count claims under the deductible.

e. Net receipts--This is the result of subtracting lines 2b, 2c, and 2d from 2a.

Item 3. Processed

a. Bills processed for payment--Report here the number of bills that were processed during the month to completion for which payment was or will be made.

1. Bills processed for payment (no investigation required)--Report here the number of bills shown in 3a which did not require an investigation (i.e., bill was not returned to sender nor was contact made with sender or other outside source by the carrier regarding the bill). This will include adjusted bills when bills are adjusted without such outside contact.

2. Bills processed for payment (investigation required)--Report here bills processed to completion which required some investigation while it was being processed, i.e., some contact with sender or other outside source.

The total of 1 and 2 should equal 3a.

b. No payment bills--Report here the number of bills processed in which a determination is made that deductible is not met or bill is beyond psychiatric maximum. This item differs from item 2d in

that services fall within scope of law but no payment is made because of limitation placed on service.

c. Total processed--Total of a and b.

Item 4. Closing Pending--Report here the total bills received but not processed to final action by the end of the month. This will be categorized by bills received in the reporting month and cases received the month prior to reporting month. Closing Pending should prove to be equal to the total opening pending plus net receipts less total processed.

Item 5. Bill Investigations--Enter here the number of bills that were investigated during the month but where the bill was not returned to the claimant. Count only the number of bills investigated not the number of contacts made.

Item 6. Reasons for investigations--Count here all reasons for which a bill was investigated, whether bill was returned to claimant or not. If bill is investigated for more than one reason record under each appropriate reason as shown on the report form.

Item 7. Returns from SSA

a. Received--Record here the total number of bills returned from SSA. Do not count bills returned from SSA in item 2a.

b. Closed--Enter here the number of bills returned from SSA that were processed and returned to SSA.

c. Pending--Enter here the number of such bills received but not yet returned to SSA.

Item 8. Informal Complaints--Report the number of persons who protest the decisions made on bills.

Item 9. Fair Hearings

a. Received--Report the number of complaints received during the month from beneficiaries which request a fair hearing.

b. Cleared--Enter here the total number of fair hearings processed to completion.

(1). Resolved for claimant--Enter here the number of fair hearings resolved in favor of beneficiary (including cases where the original decision is modified in his favor). This is a breakout of 9b.

c. Pending--Enter here the number of fair hearings still requiring resolution at end of month.

Item 10. Remarks--Self-explanatory

Signature--Space for signature of official responsible for report.
Title--Space for title of official responsible for report.
Date--Date report is completed.

6599. EXHIBITS
Exhibit 1. Report of Payment Record Layout.
Exhibit 2. Report of Payment - Input Tape Format Layout.
Exhibit 3. Carrier Workload Report.

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REPORT OF PAYMENT - RECORD LAYOUT

PAYMENT RECORD

HI CLAIM NUMBER	SURNAME	INIT	DEBIT-CREDIT	EXP. DATE FIRST YR	EXP. DATE FIRST MON	EXP. DATE LAST MON	NONPSYCH. MEDICAL CHARGES	PSYCH. MEDICAL CHARGES	DEDUCTIBLE APPLIED	REIMBURSEMENT AMOUNT	INTERMEDIARY CONTROL NUMBER	TYPE OF PHYS	TYPE OF PHYSICIAN OR SUPPLIER CODE	LARGEST AMT	PLACE OF SERV	TYPE OF SERV	NO OF CHARGES	EMPL REL	NO OF DATES	PAYMT CODE	PHYS OR SUP	SPEC CODE	‡‡	
1 2 3 4 5 6 7 8 9 10 11 12	13 14 15 16 17 18 19 20 21 22 23	24 25	26	27 28	29		30 31 32 33 34 35	36 37 38 39 40	41 42 43 44	45 46 47 48 49 50	51 52 53 54 55 56 57 58	59	60 61 62 63 64 65 66 67 68	69 70 71	72	73	74	75	76	77	78	79	80	

BATCH CONTROL TOTAL RECORD

INTERMEDIARY	BATCH NUMBER YR	BATCH NUMBER MON.	BATCH NUMBER SEQ. NO.	RCD IND	BATCH COUNT	TOTAL AMOUNT NONPSYCH MEDICAL CHARGES	TOTAL AMOUNT PSYCH MEDICAL CHARGES	TOTAL AMOUNT DEDUCTIBLE APPLIED	TOTAL AMOUNT REIMBURSEMENT		‡‡
1 2 3 4 5	6	7 8	9 10	11	12 13 14 15 16	17 18 19 20 21 22 23 24 25	26 27 28 29 30 31 32 33 34	35 36 37 38 39 40 41 42 43	44 45 46 47 48 49 50 51 52	53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79	80

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Exhibit 1

REPORT OF PAYMENT - INPUT TAPE FORMAT LAYOUT

TAPE REEL HEADER

BLANK	FILE IDENT	INTERMED NUMBER		BATCH NUMBER	BLANK	CURR PROCESS DATE	BLANK	REEL NUMBER		RCD MARK
	PAY	- ANN	BLANK			MODAYR		BLANKS		‡
	1 2 3	1 2 3 4 5	1 2 3 4	1 2 3 4 5		1 2 3 4 5 6		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52		

TAPE REEL TRAILER

TRAIL INDIC	TERM CODE	FILE RECORD COUNT		BLANKS	RCD MARK
! □ □ □ □		X X X X X X	+		‡
1 2 3 4 5		1 2 3 4 5 6		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67	

TAPE REEL FORMAT

HEADER RECORD	SINGLE DATA RECORDS	T/M	EOF TRAILER RCD	T/M

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
Budget Bureau No. 72-R739

HEALTH INSURANCE FOR THE AGED PROGRAM
CARRIER WORKLOAD REPORT
(Part B Services Only)

NAME OF CARRIER	CODE	REPORTING PERIOD *(Month and Year)*

BILL PROCESSING OPERATION		TYPE OF BILL			
		TOTAL	PHYSICIANS SERVICES	INDEPENDENT LABORATORIES	OTHER HEALTH AND MEDICAL SERVICES
1. OPENING PENDING	a. Bills pending end of last month				
	b. Adjustments in pending (+ or −)				
	c. Total Opening Pending				
2. RECEIPTS	a. Bills received this month				
	b. Bills transferred (out) (−)				
	c. Bills returned for additional information (−)				
	d. Bills rejected and returned (−)				
	e. Net Receipts				
3. PROCESSED	a. Total bills processed for payment				
	1. Bills processed for payment (No inv. required)				
	2. Bills processed for payment (Inv. required)				
	b. No payment bills processed (Deductible not met)				
	c. Total Processed				
4. CLOSING PENDING	a. Pending (received this month)				
	b. Pending (received prior month)				
	c. Total Pending				
5. BILL INVESTIGATIONS	Bills requiring investigation (Not returned to claimant)				
6. REASONS FOR INVESTIGATIONS AND RETURNS (Items 2c and 5)	a. Incomplete items				
	b. Incorrect computations				
	c. Inconsistent Diag-Serv-Proc.				
	d. Other				
7. RETURNS FROM SSA	a. Received				
	b. Cleared				
	c. Pending				
8. INFORMAL COMPLAINTS	a. Received				
9. FAIR HEARINGS	a. Received				
	b. Cleared				
	b1. Resolved for beneficiary				
	c. Pending				

10. REMARKS:

SIGNATURE

TITLE | DATE

FORM SSA-1565 (4-66)

3-179

Exhibit 3

CHAPTER VII

TRANSMITTAL AND MAINTENANCE OF CLAIMS RECORDS

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Transmittals to SSA

6601. QUERIES AND PAYMENT RECORDS TRANSMITTED TO SSA. Intermediaries using magnetic tape to query the SSA system or to furnish payment records will generally use air express to transport reels of tape to Baltimore. Intermediaries using punchcards to furnish payment records will not use air express. Punchcards cannot be used to furnish queries to SSA. Separate instructions have been issued to those intermediaries who will use teletype facilities to query SSA.

6601.1 Payment Records.--Most Part B payments will be reported to SSA in the form of a magnetic tape record or a punchcard record. If a Part B intermediary is also an intermediary for Part A, any Part B payments to a provider (made in his capacity as an A intermediary) are reported in accordance with instructions in the Part A intermediary manual. That is; provider Part B payments are reported by furnishing SSA with a copy of the provider billing form and no payment record is prepared.

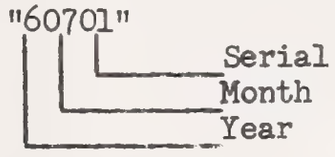
6601.2 Controls.--Each shipment of magnetic tape or punchcards containing payment records must be accompanied by a transmittal form, SSA-1606. (Exhibit 1). This form is prepared in triplicate. The original and one copy accompanies the shipment. One copy is retained by the intermediary. The following information is entered on the transmittal:

a. Intermediary identification number

b. Intermediary name and address

c. Batch number

The batch number is a 5-position number. The first or high-order position is the last digit of the year. The next two positions are the month. Positions 4 and 5 are a serial number within the month. The batch number for the first transmittal in July 1966, is shown below:



The serial position is changed so that the second transmittal in a month is "02," the third is "03," etc. The last submittal for a month is indicated by writing "final" immediately to the right of the batch number. Queries are not assigned batch numbers.

SSA will use the consecutively assigned batch numbers as a control to assure that all shipments of payment records are received. If a shipment is received with a batch number out of sequence, SSA will assume that one shipment has been lost and will contact the intermediary. The intermediary should contact SSA if a reply tape to one of his query tapes is not received within two days plus the normal "turn around" time from Baltimore.

The batch number on payment record shipments will also be used to reconcile payments made with the letter of credit procedures and for reference numbers in any correspondence regarding discrepancies or adjustments.

6603. SHIPPING INFORMATION

Most intermediaries will use air express to transmit magnetic tapes to Baltimore, since this will provide the most expeditious vehicle for shipment. However, intermediaries near Baltimore may find bus or courier service faster and more economical. Arrangements with SSA for shipment of magnetic tape by means other than air express, or punchcards by means other than mail, will be made on an individual basis.

Each reel of magnetic tape should be identified with a stick-on label showing the intermediary number (preceded by "HI" for query tape reels and "PAY" for payment record reels), the batch number (for payment records), and the recording density.

For Query reels label the tape as follows:

Date - (date prepared)

Ident. No. - HI - (your intermediary number)

Density - (5/D for CPI)

Batch No. - None

Number of Queries - (Show number of queries on tape)

For Payment Record reels label the tape as follows:

Date - (date prepared)

Ident. No. - PAY - (your intermediary number)

Density - (5/D for CPI)

Batch No. - (Year, month, and sequence number)

The tape reel with the file protect ring should be placed in a plastic reel container, and packed in a carton. The package should be noted as containing magnetic tape and marked "FRAGILE." Address to:

Social Security Administration
Bureau of Date Processing and Accounts
Attn: Tape Library
6401 Security Boulevard
Baltimore, Maryland 21235

Attach a special label (available from the air express company) instructing the company to "hold" the shipment for pick-up at the airport by SSA.

Punchcards should not be sent air express but by mail, bus, or courier service, whichever provides faster and more economical service. The punchcards must be securely packaged to avoid damage to the cards. Grouping of punchcard payment records in batches of approximately 2,000 cards is suggested. More than one batch may be included in a shipment. The transmittals forms SSA-1606 must enclosed with the cards, along with a listing of the punchcards. The package should be sent to the address given above.

6604. SCHEDULING OF REPLIES

Any shipment of magnetic tape received at Baltimore Friendship Airport by 4:00 p.m. Baltimore time will be processed by SSA that night. A reply tape for queries will be returned to the intermediary via air express the following morning. SSA will deliver reply tapes to Friendship Airport at 6:00 a.m. each morning. They will be placed on the next flight to your city. Intermediaries should make arrangement with their local air express company to "hold" these shipments for pick-up at the airport. SSA will label all shipments "hold" unless notified by an intermediary that this is not preferred.

6606. FREQUENCY OF TRANSMITTALS

Queries to SSA using magnetic tape are shipped daily or as frequently as prepared by the intermediary if the intermediary does not produce queries daily. Payment records should not be sent daily. Weekly shipment of payment records, whether magnetic tape or punchcards, is preferred by SSA.

6607. RETURN OF TAPES BY SSA

SSA will need five of each intermediary's blank tape reels prior to July 1, 1966. These reels will be used to return replies to the intermediary. After the fifth blank reel is used as a reply tape, SSA will use the retained tapes in retention date sequence as reply tapes. Consequently SSA will have a four-tape file of each

intermediary's four most recent shipments available in Baltimore if reprocessing is necessary.

Payment record tapes will be returned by SSA immediately where the tapes are out of balance. Those tapes which are in balance in the preliminary edit will be returned after SSA is assured that the output from the preliminary edit has been processed in the weekly operation. The return of an in-balance tape may be construed as a notification that the intermediary may release his "back-up" tape.

6610. DISCREPANT BILLS

SSA will return batches of payment records, the individual punch-card removed from a batch, or a hard copy record of a payment record because of apparent discrepancies in batch totals, or in a particular field of the payment record. Items may also be returned for reasons such as the following:

1. Apparent discrepancy in the payment calculation.

2. Edit conditions in the data contained in the payment record.

3. Incorrect health insurance claim number or name of beneficiary.

4. Deductible not met.

5. Beneficiary not entitled to Part B.

6. Payments for outpatient psychiatric charges in excess of maximum allowable.

SSA will adjust the intermediary's reimbursement control totals maintained in SSA and will notify the intermediary of such adjustments. SSA will identify the batches involved as well as the reason the items are being returned.

The intermediary must make corresponding adjustments to his disbursement controls. (In some instances, action may need to be initiated for recovery of moneys overpaid.) Where the intermediary resolves the discrepancy he may resubmit the payment record in another batch under a new batch number.

6612. OTHER ACTIONS AND MATERIAL

In addition to cases removed from the processing system prior to the updating of the utilization records, certain cases may be returned to the intermediary after the completion of all SSA processing.

Such cases could involve requests for development or investigation of some aspect of the case or verification of certain data.

After the intermediary's action is completed, such cases should be returned to SSA as individual items and not included in the shipment of regular payment records, the cases should be clearly identified as cases not requiring processing. Generally, such cases should be returned by letter mail to the organizational component which requested the action.

6615. CONTINUOUS STATISTICAL SAMPLE FORMS
On a daily basis or a minimum of 3 times weekly all sample forms will be sent to:

Social Security Administration
Bureau of Data Processing and Accounts
Civic Howard Building
211 West Lombard Street
Baltimore, Maryland 21201

Before shipment each of the sample forms should have the intermediary number entered in the upper left corner of the form. The forms should be blocked in batches of approximately 100. Any bills or other forms accompanying the Request for Payment form must be securely attached to the Request for Payment form. Each shipment of bills must be sent under cover of a transmittal, form SSA-1575. (Exhibit 2) The SSA-1575 should be prepared in duplicate with the original accompanying the shipment to SSA and the duplicate maintained by the intermediary. Enter the following information on the SSA-1575 in the appropriate spaces:

a. Intermediary identification number

b. Intermediary's name and address

c. Batch date

d. Batch number - A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. If an intermediary has more than one paying office submitting records directly to SSA, each individual office must maintain separate consecutive batch numbers for records they submit.

e. Total number of bills

Files Maintenance

6620. GENERAL PROVISIONS

Subject to the provisions of the Code of Federal Regulations, Title 41, the Social Security Administration has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, the Secretary is required to provide for effective controls over the creation of records including the making of records containing adequate and proper documentation of the intermediary's administration and operations. The claims records referred to in this chapter are designated as Government records comprising Government-issued standard forms and other supporting forms needed to document claims records. Such Government forms will be developed, issued, printed, and distributed by the Social Security Administration and will be maintained by the intermediary, in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials.

Each Part B intermediary is required to establish and maintain an active continuing program for the economical and efficient management of its claims transaction records under the health insurance program. Accordingly, intermediary record programs should provide for:

(1) Effective control over the creation, the organization, maintenance, use, and disposition of all Social Security Administration health insurance claims records. Files are to be organized so that needed records can be found rapidly; complete records are insured; the selection and retention of records of value are facilitated; and the disposal of noncurrent records is accomplished with maximum economy in personnel, equipment, and supplies;

(2) Cooperation with SSA in developing and applying standards, procedures, and techniques designed to improve the management of claims records, assure the maintenance and security of records of continuing value, and facilitate the segregation and disposal of all records of temporary value.

6620.1 Files Defined.--A file is basically a paper or folder of papers, but the term is used to denote papers, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, or on shelves, and occupying office or storage space. Stocks of publications and blank forms are excluded from the definition. Specifically the files affected by these instructions relate to transactions involved in the processing and payment of claims for services rendered to health insurance beneficiaries.

6620.2 Creation of Files for Records.--Adequate records management controls over the creation of intermediary files should be instituted to insure that routine operational paper work is kept to a minimum and that the accumulation of unnecessary files is prevented. Effective techniques to be applied in this area include the control of correspondence and forms; the minimizing of duplicate files; and the immediate disposal of transitory material that has no value for record purposes.

6620.3 Files Program Requirements.--Each intermediary, in providing controls over the creation of records, is expected to establish an appropriate program for the management of intermediary files. The program will:

A. Establish and implement standards and procedures issued by SSA for:

1. Classifying, indexing, and filing records.

2. Providing reference services to filed records.

3. Locating active files to facilitate use of the records.

4. Reviewing the program periodically to determine the adequacy of the system and its effectiveness in meeting requests.

B. Insure that the standards, guides, and instructions developed for the files management program should be readily available to all employees concerned with the files operations. In addition, pertinent information for users of files and reference services should be given the widest possible dissemination.

6622. FILES PROGRAM IMPLEMENTATION

The following actions are generally basic to a files management program:

A. Standardize classification and filing schemes to:

1. Achieve maximum uniformity and ease in maintaining and using program records.

2. Facilitate disposal of records in accordance with applicable records disposal schedules.

3. Facilitate possible later consolidation of identical type files presently maintained at different locations.

B. Formally authorize official file locations. Prohibit the maintenance of files at other than authorized locations.

C. Standardize reference service procedures to facilitate the finding, charge-out, and refiling of records.

D. File accumulations of papers received at file locations on a daily basis.

E. Audit periodically a representative sample of the files for duplications, misclassification, or misfiles.

6623. ORGANIZATION, MAINTENANCE, AND USE OF FILES
Provision shall be made for the continued analysis and improvement of such matters as record classification and indexing systems, the use of filing equipment and supplies, the reproduction and transportation of records, and to assure that records are maintained economically and efficiently, and in such a manner that their maximum usefulness is attained.

The files established by the intermediary, and all records and procedures documenting the intermediary programs for controlling the creation, maintenance, and use of current records; for the selective retention of records of continuing value; and for the disposal of noncurrent records will be available for periodic review by the Social Security Administration.

6625. DESCRIPTION OF FILES MAINTAINED
The methods of maintaining and clearing temporary pending files and closed bill files will vary with the intermediary. These will depend on the filing and control methods established by health insurance claim number, name, carrier claim or control number, or other sequence to record requests; to furnish replies; to check on overdue cases; to control cases for completion of processing and payment; to control cases requiring some type of investigation or additional documentation; to retain completed cases for history or other reference; to maintain for audits; and to schedule for transfer to other storage areas.

Other variances in the intermediary's methods of filing will depend on computer or clerical practices; workload volume; method of referral or association with provider billing forms furnished by other intermediaries; review initiated at time of receipt of the request for payment or other billing form; use or non-use of telecommunications networks; and other considerations.

Regardless of the practices generally followed by the intermediary, the SSA procedures and workflow may require certain adaptation to effectively coordinate the workflow and interaction between the interests of health insurance beneficiaries, furnishers of medical and other health services, other intermediaries, and the central SSA recordkeeping and processing operations.

The following descriptions and workflow relate to files maintenance operations according to the pattern of the individual carrier.

6625.1 File Pending Receipt of Physicians Bills.--The Part A intermediary will forward copies of Part A bills to the Part B carrier for use in reviewing physicians' bills. The carrier will maintain the copies of the Part A bills in a pending file to await receipt of the physicians' bills.

This file will generally be maintained in health insurance claim number or other acceptable sequence permitting identification, association, or referral.

6625.2 File Pending Receipt of Reply to Status Inquiry.--The intermediary will transmit status inquiry data to the Social Security Administration after receipt of requests for payment. A pending file of status inquiries or equivalent data should be maintained by the intermediary to await receipt of the reply to the status inquiry from SSA.

This file should generally be maintained in health insurance claim number sequence, date sequence, or other sequence designed to facilitate association of inquiries with replies and to identify inquiries requiring followup requests.

6625.3 File Pending Receipt of Reply to Development Requests.--In selected cases, Part B intermediaries will have need to initiate development to reconcile incomplete, inconsistent, or inaccurate entries on requests for payment or other forms or documents. Pending the receipt of the reply to any such development request, the intermediary will hold the claims material in a Current Pending File.

This file will generally be maintained in health insurance claim number or other acceptable sequence.

6625.4 File Pending Posting of Claims Data into the Records of the Social Security Administration.--The intermediary's copies of transmitted payment records and listings for cards should be maintained by the intermediary for a period of one month in a

closed temporary file to facilitate current reference and such reconciliation operations as may be required.

This file will ordinarily be maintained in batch number sequence corresponding to the batches forwarded to SSA for posting to EDP records. (This file may be maintained in some other sequence, provided the intermediary's system will permit speedy location and association of claims related materials.)

6625.5 Permanent Record File.--After all action as to reimbursement and posting to SSA records is completed, and the one-month period set out in § 6625.4 above has passed, the requests for payment and related materials will be retired to a permanent claims record file.

This file will generally be maintained in yearly files in transmittal batch number, date, health insurance claim number, or other acceptable sequence.

This file will be used to conduct audits; to serve as a reference file to refer to specific bills in order to obtain detailed information or medical history of health insurance beneficiaries; to answer status requests, complaints, or other correspondence relative to a particular bill; to document the record in cases involving hearings; and to accommodate other needs which may be presented in the successful administration of the program.

6625.6 List of Part B Claims Materials.

a. Part B status inquiry.

b. Reply to status inquiry.

c. Request for payment and other bill documentation (Forms SSA-1453, SSA-1485, SSA-1487, SSA-1483, SSA-1490, and SSA-1554).

d. Deductible information.

e. Terminations of coverage.

f. Representative payee information.

g. Payment records and vouchers.

h. Death notices.

i. Fair hearings records.

j. Medical or hospital record documentation resulting from investigation or certification requirements.

k. Any other claims-related materials peculiar to specific transactions under the program, necessary for reasons of documentation.

6628. RETENTION OF CLAIMS FILES MATERIALS
Provision shall be made to insure that records of continuing value are preserved, but that records no longer of current use to the program are promptly disposed of or retired.

6628.1 Standard Retention Period (At Least Six Months).--Claims materials and other adequate records concerning the use of funds under Part B shall ordinarily be maintained by the Part B intermediary until the expiration of not less than 6 months after the date of initial payment, after which the records will be transferred to a Federal Records Center. Bills will be forwarded from the intermediary's storage area to the Federal Records Center in January and August of each year. The dispatch in January will contain those bills paid in the 6-month period, January through June of the previous year. The dispatch in August will consist of bills paid in the 6-month period, July through December of the previous year. The first transfer is scheduled for August 1967.

NOTE: After the bill-review process is completed, no further changes, deletions, strike-overs, or other entries should be made on the forms or claims materials except as provided by SSA instructions.

6628.2 Modification of the Standard Retention Period.

A. Yearly or Bi-Yearly Period.--Approval may be given for those intermediaries with a small claims volume or those having both Part A (provider services) and Part B (physician services) responsibilities to combine records (rather than maintain them separately by batch number; for example, as in health insurance claim number sequence by calendar year or by 2-year calendar year period). Such intermediaries would be of the type where clerical operations require case examination of prior history file for detection of duplicate claims; incurred date sequence; bill-review for coverage patterns and other consistency checks. Variations in retention period could depend on volume, degree of reference, etc.

The period of retention and transfer here could be the same as the standard, or after specific approval on an individual

intermediary basis, by a 1-or-2 year health insurance claim number sequence, permitting transfer every year or second year, as in the following examples:

Example 1:

7/1/66 - 12/31/66	Segment 1:	
1/1/67 - 12/31/67	Segment 2:	
1/1/68 - 12/31/68	Segment 3:	at 1/1/68, transfer Segment #1.
1/1/69 - 12/31/69	Segment 4:	at 1/1/69, transfer Segment #2.

Each year, begin a new active file segment.

Example 2:

7/1/66 - 6/30/67	Segment 1:	
7/1/67 - 6/30/68	Segment 2:	at 1/1/68, transfer Segment #1.
7/1/68 - 6/30/69	Segment 3:	at 1/1/69, transfer Segment #2.

Example 3:

7/1/66 - 6/30/68	Segment 1:	
7/1/68 - 6/30/70	Segment 2:	at 1/1/69, transfer Segment #1.
7/1/70 - 6/30/72	Segment 3:	at 1/1/71, transfer Segment #2.

B. Bi-Monthly Period.--Approval may be given for those intermediaries who have been authorized to microfilm claims records (on the basis of individual submittals including documented cost justifications)--to retain original source documents for 2 months before transfer to the Federal Records Center. Each month a transfer of a 2-month matured segment will be made.

Example:

7/1/66 Records --transfer 9/1/66
8/1/66 Records --transfer 10/1/66

Other modifications of the retention period may be approved by SSA after giving detailed consideration to the experiences with retained and recalled records; the type of references to individual records; the degree and frequency of any such reference; audits, studies, and other usages having a bearing on periods of retention.

6629. DOCUMENTATION OF FILE REFERENCES AND REQUESTS FOR MODIFICATION
Under all retention systems (monthly intervals for microfilmers; 6-month standard intervals; or 1-or-2-year intervals for smaller volume clerical processors), the intermediaries should document by monthly tally, the number of records requiring post-bill review reference. Show the reason for reference; number of references

and length of time after bill is processed. Exclude from this tabulation all references arising from current processing to reconcile batches.

Example:

Tabulate: Reason	Number	Months after Bill Review
SSA Request (indiv.)	--	1
" " "	--	2
" " "	--	3 etc.
SSA Request (study)	--	
HI Beneficiary Request	--	1
" " "	--	2
" " "	--	3 etc.
DHEW AUDIT	--	1
" "	--	2
" "	--	3 etc.

On the basis of such data, submittals may be initiated to obtain approval for a modified period of retention. Such a request should be sent to the following address:

Social Security Administration
Bureau of Health Insurance
Division of Methods and Procedures
Room 4Q6 Operations Building
Baltimore, Maryland 21235

Evaluation of these tabulations, together with study and audit findings and evaluations by SSA, will be used to develop later procedures to provide for earlier transfer or selected destruction of materials, as warranted.

6630. TRANSFER OF CLAIMS FILE MATERIALS

Bills and related claims materials may be transferred to Federal Records Centers after the period of retention set forth in § 6628. No records shall be transferred from one intermediary to another, to other storage spaces, or to the Federal Records Center except pursuant to written instructions issued by the Social Security Administration.

Detailed instructions will be issued to the intermediary before the first schedules transfer to the Federal Records Center. These instructions will concern the methods of transferring claims

materials to Federal Records Centers and the method of recalling specific claims materials, if necessary, from Federal Records Centers. The instructions will include the locations of the Federal Records Centers to which the individual intermediaries will transfer records.

6699. EXHIBITS

Exhibit 1. Payment Record Transmittal, SSA-1606.

Exhibit 2. Advice of Transmittal - Medical Insurance Statistical Sample, SSA-1575.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
Budget Bureau No. 72-R757

PAYMENT RECORD TRANSMITTAL

MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

DELIVER TO:	INTERMEDIARY IDENTIFICATION
Social Security Administration Bureau of Data Processing and Accounts Attn: Tape Library 6401 Security Boulevard Baltimore, Maryland 21235	NUMBER NAME AND ADDRESS

MATERIAL INCLUDED IN THIS TRANSMITTAL

BATCH NUMBER	DATE BATCHED	NUMBER OF TAPE REELS OR BOXES OF CARDS *(Specify tape reels or boxes of cards)*

TOTAL NUMBER OF ITEMS IN BATCH	TOTAL REIMBURSEMENT AMOUNT

SSA PROCESSING DATA

REMARKS

☐ ENTIRE BATCH BEING RETURNED ☐ SEE ATTACHED LIST

DATE

FORM **SSA-1606** (6-66)

REFERENCE MINEOGRAPH 6995

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
Budget Bureau No. 72-R745

ADVICE OF TRANSMITTAL – MEDICAL INSURANCE STATISTICAL SAMPLE

DELIVER TO:	INTERMEDIARY IDENTIFICATION
Social Security Administration Bureau of Data Processing and Accounts Civic-Howard Building 211 West Lombard Street Baltimore, Maryland 21201 Attn: Medical Insurance	NUMBER NAME AND ADDRESS

MEDICAL INSURANCE BILLS INCLUDED IN THIS TRANSMITTAL

BATCH NUMBER	DATE BATCHED
TOTAL NUMBER OF PAYMENT REQUESTS IN BATCH	TYPE OF BILLS

SSA PROCESSING TOTALS

DATE RECEIVED	VERIFIED COUNT	+ OR –	NUMBER RETURNED	PUT IN PROCESS

FORM **SSA-1575** (6-66)

U.S. GOVERNMENT PRINTING OFFICE : 1966 O—224-878

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
MAR 13 1967
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HEALTH INSURANCE FOR THE AGED

HIM - 14
PART B INTERMEDIARY MANUAL

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

Cur. Mk
HV
1457
A45
no. 14-1

August 10, 1966

PART B INTERMEDIARY MANUAL

REVISION TRANSMITTAL NO. 1

New Material	Page No.	Replaced Pages
Check Sheet for Revision Transmittals		
Table of Contents, Chap. VI	145	145
Sec. 6532 (Cont'd) - 6534	165 - 166.2	165-166

This Revision Transmittal forwards a new section, 6533, Contents of Payment Records for Partially Paid Bills, with instructions on the preparation of payment records where reimbursement is being made on the basis of a partially paid bill. These instructions are effective immediately.

We have also included a check sheet for use of manual holders in recording receipt of revision transmittals.

Arthur E. Hess, Director
Bureau of Health Insurance

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
SEP 27 1966
LIBRARY

8-66 CHECK SHEET OF PART B INTERMEDIARY MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword, to provide a record of Manual revisions received. Part B Intermediary Manual revisions will be issued under cover of numbered "Revision Transmittals."

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.		21.		41.		61.		81.	
2.		22.		42.		62.		82.	
3.		23.		43.		63.		83.	
4.		24.		44.		64.		84.	
5.		25.		45.		65.		85.	
6.		26.		46.		66.		86.	
7.		27.		47.		67.		87.	
8.		28.		48.		68.		88.	
9.		29.		49.		69.		89.	
10.		30.		50.		70.		90.	
11.		31.		51.		71.		91.	
12.		32.		52.		72.		92.	
13.		33.		53.		73.		93.	
14.		34.		54.		74.		94.	
15.		35.		55.		75.		95.	
16.		36.		56.		76.		96.	
17.		37.		57.		77.		97.	
18.		38.		58.		78.		98.	
19.		39.		59.		79.		99.	
20.		40.		60.		80.		100.	

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
101.		126.		151.		176.		201.	
102.		127.		152.		177.		202.	
103.		128.		153.		178.		203.	
104.		129.		154.		179.		204.	
105.		130.		155.		180.		205.	
106.		131.		156.		181.		206.	
107.		132.		157.		182.		207.	
108.		133.		158.		183.		208.	
109.		134.		159.		184.		209.	
110.		135.		160.		185.		210.	
111.		136.		161.		186.		211.	
112.		137.		162.		187.		212.	
113.		138.		163.		188.		213.	
114.		139.		164.		189.		214.	
115.		140.		165.		190.		215.	
116.		141.		166.		191.		216.	
117.		142.		167.		192.		217.	
118.		143.		168.		193.		218.	
119.		144.		169.		194.		219.	
120.		145.		170.		195.		220.	
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Number of Columns	Item	Description
		9. Other Medical Services - Services falling in the following special categories: ⊠ rental of durable medical equipment ⊠ ambulance service ⊠ internal and external prosthetic devices and appliances ⊠ supplies
(1)	Number of Separate Itemized Charges	A count of the number of separate charges shown on the request for payment or on the other billing forms (including receipted bills) to which the specific Payment Record relates. Use "9" for 9 or more.
(1)	Employment Relationship	A code showing whether or not the illness or injury requiring treatment was related to the beneficiary's employment. Use the information supplied by the beneficiary on the Request for Payment Form SSA-1490. Code as follows: "1" for "yes" (connected with employment) "2" for "no" (not connected with employment) "3" for information not available
(1)	Number of Dates of Service	The number of separate dates of service incurred listed on the bill attachment or on the request for payment. (Where the count of these items is over 9, show "9.")
(1)	Payment Code	A code showing whether the payment being recorded was made to the beneficiary, to the physician or

Number of Columns	Item	Description
		supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill) or to a provider where the provider bills for physician. Code as follows: "1" for payment to physician or supplier "2" for payment to beneficiary "3" for partial payment to both "4" for payment to provider (hospital-based physicians) "5" for partial payment to both provider and beneficiary "6" for payment to group practice prepayment plan "7" for payment to other entities
(2)	Physician or Supplier Specialty	A two-digit code for <u>each</u> physician or supplier of other medical services dealing with the intermediary, showing the physician's specialty or the type of supplier. The same codes as shown in §§ 6520.1 and 6520.2 of this chapter will be used.

Some intermediaries may not be able to provide information about: (1) Board Certification and (2) Physician or Supplier Specialty on July 1, 1966 because they do not have the necessary information. Both items should be added to the payment record as soon as possible after July 1, 1966 and in no event later than January 1, 1967. Intermediaries should notify the SSA as to when they plan to add these two items to the payment record, if they will not be doing so on July 1, 1966.

6533. CONTENT OF PAYMENT RECORDS FOR PARTIALLY PAID BILLS

Payment Records for partially paid bills will be prepared in accordance with the applicable instructions in the sections above.

The content of Payment Records for bills where reimbursement is being made, either to a beneficiary or a physician, on the basis of a partially paid bill, will depend on whether or not the bill has been assigned.

When a physician accepts assignment of such a bill, the Payment Record should be prepared as if the beneficiary had made no partial payment. The fact that a partial payment had been made would be reflected by use of the proper "Payment Codes" in the Payment Record. Payment code "3" or "5" would be used as appropriate.

Where a physician does not accept assignment for the unpaid portion of the bill, the following special instructions should be used:

A. On initial receipt of a partially paid bill where there is no assignment 2 payment records will be prepared as follows:

1. One payment record will show all of the information relating to the total bill. It will be treated as if it were a fully paid bill and a payment record prepared in the normal way with one exception. This exception is that no money amount will be shown in the "reimbursement amount" field of the record. In this field in the "cents" portion the letters "PP" must be shown to identify this type of payment record. Because of the exclusion of a money amount in this field in this type of payment record the built in balancing factor on money amounts within a regular payment record is of course, not applicable.

2. A second skeleton payment record will be prepared showing only the following fields as specified:

(1) HI Claim Number (same as normal payment record)

(2) Surname (same as normal payment record)

(3) Initials (same as normal payment record)

(4) Debit-Credit Code (same as normal payment record)

(5) Expense Year (same as normal payment record)

(6) Reasonable Medical Charges (Non-psychiatric). Show the amount of the total reasonable non-psychiatric charges that have been paid by the beneficiary plus any portion of the unpaid amount being credited toward the deductible.

(7) Outpatient Psychiatric Expense. Show the reasonable psychiatric expenses that have been paid by the beneficiary plus any portion of the unpaid amount being credited toward the deductible. The general limitation on outpatient psychiatric expense of the lesser of 62 1/2 percent or $312.50 also applies here.

(8) Deductible Applied. Show any amount of incurred expenses paid or unpaid included in the amounts shown in (6) and/or (7) above that are being applied to the deductible.

(9) Reimbursement Amount. Show 80 percent of [(6)+(7)]-(8)

(10) Intermediary Control Number (same as normal payment record)

(11) Employment Relationship (same as normal payment record)

(12) PP (show the letters PP in the field normally used for physician specialty code--these letters must be present in this type of payment record)

(13) Record Mark (same as normal payment record)

B. On subsequent receipt of partially paid bill where there is no assignment (second, and third partial payments, etc.), prepare only the skeleton payment record specified in "A2" above.

Note: Extreme caution must be exercised regarding the deductible (which can be considered met out of the unpaid portion of such bills) when handling these 2nd, 3rd, etc., partial payments to assure that reimbursement is not made for deductible amounts. Possibly for the last or the last 2 bills submitted by the beneficiary in these situations, depending upon the amounts involved, no reimbursement may be involved and if not, no payment record should be prepared.

C. Some partially paid bills will fall into the "Continuous Bill Sample." For those that do, only the first one showing complete information regarding the total bill should be sent to Baltimore with the annotation next to the reimbursement amount "partial payment."

D. The batch count field of the batch control record should include the total of both types of payment records.

Preparing Payment Records Prior to Transmission to SSA

6534. BATCHING PAYMENT RECORDS

It is suggested that punchcard reporting intermediaries group payment records in batches of 2,000 when preparing to transmit them to SSA. When reporting is made by magnetic tape, the entire tape may be one batch or there may be more than one batch on a tape. Where more than one batch is submitted on a tape, a header

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no.14-2

August 20, 1966

PART B INTERMEDIARY MANUAL

REVISION TRANSMITTAL NO. 2

New Material	Page No.	Replaced Pages
Sec. 6603 (Cont.) - 6620.1	185-188	185-188

Sections 6603 and 6606 have been changed to incorporate the instructions in Intermediary Letter No. 110 on removal of the file protect ring prior to shipment of magnetic tape reels, and the prohibition against intermixing of payment records for which reimbursement has been made in one calendar month in a batch with records for which payment is made in the next calendar month. Intermediary Letter No. 110 may be discarded.

Arthur E. Hess, Director
Bureau of Health Insurance

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The tape reel should be placed in a plastic reel container and packed in a carton. The file protect ring should be removed prior to packaging. The package should be noted as containing magnetic tape and marked "FRAGILE." Address to: Social Security Administration, Bureau of Data Processing and Accounts, Attn: Tape Library, 6401 Security Boulevard, Baltimore, Maryland 21235.

Attach a special label (available from the air express company) instructing the company to "hold" the shipment for pick-up at the airport by SSA.

Punchcards should not be sent air express; but by mail, bus, or courier service, whichever provides faster and more economical service. The punchcards must be securely packaged to avoid damage to the cards. Grouping of punchcard payment records in batches of approximately 2,000 cards is suggested. More than one batch may be included in a shipment. The transmittals forms SSA-1606 must be enclosed with the cards, along with a listing of the punchcards. The package should be sent to the address given above.

6604. SCHEDULING OF REPLIES

Any shipment of magnetic tape received at Baltimore Friendship Airport by 4:00 p.m. Baltimore time will be processed by SSA that night. A reply tape for queries will be returned to the intermediary via air express the following morning. SSA will deliver reply tapes to Friendship Airport at 6:00 a.m. each morning. They will be placed on the next flight to your city. Intermediaries should make arrangement with their local air express company to "hold" these shipments for pick-up at the airport. SSA will label all shipments "hold" unless notified by an intermediary that this is not preferred.

6606. FREQUENCY OF TRANSMITTALS

Queries to SSA using magnetic tape are shipped daily or as frequently as prepared by the intermediary if the intermediary does not produce queries daily. Payment records should not be sent daily. Weekly shipment of payment records, whether magnetic tape or punchcards, is preferred by SSA.

On the last day of the calendar month all outstanding payment record batches should be transmitted to SSA. Payment records for which reimbursement has been made in the current calendar month should not be intermixed and transmitted in a batch with records for which payment will be made in the next calendar month.

To avoid transmitting small batches of payment records to SSA, if the month ends one or two days after the intermediary would normally have transmitted a batch to SSA, that batch should be

held over to include payment records processed on those days. Conversely, if the month begins one or two days before the intermediary would normally start accumulating another batch, the payment records processed during the first one or two days of the month should be included in that first full batch rather than cutting-off and submitting as a separate batch those payment records processed during those one or two days.

6607. RETURN OF TAPES BY SSA

SSA was initially furnished five blank tape reels by each intermediary using magnetic tape. These reels will be used to return replies to the intermediary. SSA will use the retained tape reels in retention date sequence as reply tapes. Consequently, SSA will have a four-tape file of each intermediary's four most recent shipments available in Baltimore if reprocessing is necessary.

Payment record tapes will be returned by SSA immediately where the tapes are out of balance. Those tapes which are in balance in the preliminary edit will be returned after SSA is assured that the output from the preliminary edit has been processed in the weekly operation. The return of an in-balance tape may be construed as a notification that the intermediary may release his "back-up" tape.

6610. DISCREPANT BILLS

SSA will return batches of payment records, the individual punch-card removed from a batch, or a hard copy record of a payment record because of apparent discrepancies in batch totals, or in a particular field of the payment record. Items may also be returned for reasons such as the following:

1. Apparent discrepancy in the payment calculation.
2. Edit conditions in the data contained in the payment record.
3. Incorrect health insurance claim number or name of beneficiary.
4. Deductible not met.
5. Beneficiary not entitled to Part B.
6. Payments for outpatient psychiatric charges in excess of maximum allowable.

SSA will adjust the intermediary's reimbursement control totals maintained in SSA and will notify the intermediary of such adjustments. SSA will identify the batches involved as well as the reason the items are being returned.

The intermediary must make corresponding adjustments to his disbursement controls. (In some instances, action may need to be

initiated for recovery of moneys overpaid.) Where the intermediary resolves the discrepancy, he may resubmit the payment record in another batch under a new batch number.

6612. OTHER ACTIONS AND MATERIAL
In addition to cases removed from the processing system prior to the updating of the utilization records, certain cases may be returned to the intermediary after the completion of all SSA processing. Such cases could involve requests for development or investigation of some aspect of the case or verification of certain data.

After the intermediary's action is completed, such cases should be returned to SSA as individual items and not included in the shipment of regular payment records, the cases should be clearly identified as cases not requiring processing. Generally, such cases should be returned by letter mail to the organizational component which requested the action.

6615. CONTINUOUS STATISTICAL SAMPLE FORMS
On a daily basis or a minimum of 3 times weekly all sample forms will be sent to: Social Security Administration, Bureau of Data Processing and Accounts, Civic Howard Building, 211 West Lombard Street, Baltimore, Maryland 21201.

Before shipment each of the sample forms should have the intermediary number entered in the upper left corner of the form. The forms should be blocked in batches of approximately 100. Any bills or other forms accompanying the Request for Payment form must be securely attached to the Request for Payment form. Each shipment of bills must be sent under cover of a transmittal, form SSA-1575. (Exhibit 2) The SSA-1575 should be prepared in duplicate with the original accompanying the shipment to SSA and the duplicate maintained by the intermediary. Enter the following information on the SSA-1575 in the appropriate spaces:

a. Intermediary identification number

b. Intermediary's name and address

c. Batch date

d. Batch number - A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. If an intermediary has more than one paying office submitting records directly to SSA, each individual office must maintain separate consecutive batch numbers for records they submit.

e. Total number of bills

Files Maintenance

6620. GENERAL PROVISIONS

Subject to the provisions of the Code of Federal Regulations, Title 41, the Social Security Administration has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, the Secretary is required to provide for effective controls over the creation of records including the making of records containing adequate and proper documentation of the intermediary's administration and operations. The claims records referred to in this chapter are designated as Government records comprising Government-issued standard forms and other supporting forms needed to document claims records. Such Government forms will be developed, issued, printed, and distributed by the Social Security Administration and will be maintained by the intermediary, in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials.

Each Part B intermediary is required to establish and maintain an active continuing program for the economical and efficient management of its claims transaction records under the health insurance program. Accordingly, intermediary record programs should provide for:

(1) Effective control over the creation, the organization, maintenance, use, and disposition of all Social Security Administration health insurance claims records. Files are to be organized so that needed records can be found rapidly; complete records are insured; the selection and retention of records of value are facilitated; and the disposal of noncurrent records is accomplished with maximum economy in personnel, equipment, and supplies;

(2) Cooperation with SSA in developing and applying standards, procedures, and techniques designed to improve the management of claims records, assure the maintenance and security of records of continuing value, and facilitate the segregation and disposal of all records of temporary value.

6620.1 Files Defined.--A file is basically a paper or folder of papers, but the term is used to denote papers, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, or on shelves, and occupying office or storage space. Stocks of publications and blank forms are excluded from the definition. Specifically, the files affected by these instructions relate to transactions involved in the processing and payment of claims for services rendered to health insurance beneficiaries.

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PART B INTERMEDIARY MANUAL

REVISION TRANSMITTAL NO. 3

The following changes should be made to Part 1, Fiscal Administration, of the Part B Intermediary Manual.

New Material	Page No.	Replaced Pages
Table of Contents	i	i
Table of Contents	41	41
Table of Contents	53	53
Table of Contents	85	85

These pages were reprinted to correct the page references.

Action Items

Please make the following pen and ink corrections:

Page 9, Third line from bottom; change the word convenants to covenants.
Page 13, Fourth line from bottom of page; change the word or to of.
Page 17, Last line 4150 D; change the word therefore to therefor.
Page 27, Insert the following paragraph at the bottom of the page;
Total Costs - Column (e)--Column (e) represents the total of columns (c) and (d).
Page 43, Ninth line of 4302; change the word Expenses to Costs.
Page 59, Second last line of 4410.2; change the word designated to designed.
Page 61, First line on the page; change the word leter to later.
Page 67, Middle of page; first line of column (d); change (date to be furnished) to August 1, 1966.
Page 68, The second sentence of reference to line 18b; change the word extent to extend.
Page 87, Third line of 4504; change the word herinafter to hereinafter.

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Arthur E. Hess, Director
Bureau of Health Insurance

PART B INTERMEDIARY MANUAL

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A45
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August 30, 1966

PART B INTERMEDIARY MANUAL

REVISION TRANSMITTAL NO. 4

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New Material	Page No.	Replaced Pages
Table of Contents, Chap. VI	145	145
Sec. 6532 (Cont'd) - 6532 (Cont'd)	161-162	161-162
Sec. 6532.1 - 6534	166.1-166.3	166.1-166.2

This Revision Transmittal makes the following changes in Part 3:

Sec. 6532 - On page 162, an addition has been made to the "Largest Single Reasonable Charge" item to indicate that an amount less than 50 cents is to be shown as "000." A note is also added that this is the only payment record field where cents are rounded off.

Action Item--A pen and ink correction should be made on page 166 to change the numbering of section 6533 to 6532.1.

Sec. 6532.2--This is a new section containing instructions for preparation of Payment Records where hospitals bill for the hospital-based physician component in the name of the department head. These instructions are effective immediately.

Arthur E. Hess, Director
Bureau of Health Insurance

(Part B Intermediary Manual Revision Transmittal No. 3 had limited distribution only to holders of Part 1, Fiscal Administration, of the Manual. Holders of Part 3 who do not receive Part 1 should so annotate their Revision Transmittal check sheets.)

CHAPTER VI

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Number of Columns	Item	Description
(5)	Outpatient Psychiatric Expense	The outpatient psychiatric expense represents 62½% or $312.50 (whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment form for which payments have been made.
(4)	Deductible Applied	Amount of the incurred expenses (medical and/or psychiatric) in this record which were applied to the deductible.
(6)	Reimbursement Amount	The amount of payment made to or on behalf of the beneficiary.

NOTE:

	Reasonable Medical Charges
Plus	Psychiatric Expense
Less	Deductible Applied
Multiplied	by 80%
Equals	Reimbursement Amount

(8)	Intermediary Control Number	The control number assigned by the intermediary to the individual bill. SSA may use this number for case identification in correspondence, etc., with the intermediary.
(1)	Type of Physician & Board Certification	A code showing whether the physician is an M.D., DO, DDS, or DMD and whether he is certified by a specialty Board. This information is available from directories issued by the American Medical Association and State and local medical societies. Code as follows: "1" for MD - Board certified "2" for MD - not Board certified "3" for MD - Board certification not known "4" for DO - Board certified "5" for DO - not Board certified "6" for DO - Board certification not known

Number of Columns	Item	Description
		"7" for DDS/DMD - Board certified "8" for DDS/DMD - not Board certified "9" for DDS/DMD - Board certification not known "0" for bills not involving physicians' services
(9)	Physician or Supplier Code	The number that the intermediary uses to identify each individual physician or medical supplier (ambulance service, clinical laboratory, medical supply house, etc.). Intermediaries may use the numbers that are currently in use. These numbers may be license numbers, tax numbers, social security numbers, or simple serial numbers. Only one number should be used for an individual physician or supplier in connection with the HIB program.
(3)	Largest Single Reasonable Charge	Amount of money rounded to the nearest dollar for the item of service on the bill which is determined to have the largest reasonable charge. For bills showing only one service, the amount would be the charge for that service. For bills showing several services with the same reasonable charge for each, enter here the charge for the first service shown on the bill. If greater than $999, show as 999. If less than $.50 (50 cents), show as 000.

NOTE: This is the only field in the payment record where cents are rounded off. All other money fields in payment records show both dollars and cents.

(1)	Place of Service	Show here the place where the service having the largest single reasonable charge (as identified in the item above) was rendered, using the following classification: Code as follows: "1" - Office "2" - Home "3" - Inpatient Hospital "4" - Extended Care Facility

When a physician accepts assignment of such a bill, the Payment Record should be prepared as if the beneficiary had made no partial payment. The fact that a partial payment had been made would be reflected by use of the proper "Payment Codes" in the Payment Record. Payment code "3" or "5" would be used as appropriate.

Where a physician does not accept assignment for the unpaid portion of the bill, the following special instructions should be used:

A. On initial receipt of a partially paid bill where there is no assignment 2 payment records will be prepared as follows:

1. One payment record will show all of the information relating to the total bill. It will be treated as if it were a fully paid bill and a payment record prepared in the normal way with one exception. This exception is that no money amount will be shown in the "reimbursement amount" field of the record. In this field in the "cents" portion the letters "PP" must be shown to identify this type of payment record. Because of the exclusion of a money amount in this field in this type of payment record the built in balancing factor on money amounts within a regular payment record is of course, not applicable.

2. A second skeleton payment record will be prepared showing only the following fields as specified:

(1) HI Claim Number (same as normal payment record)

(2) Surname (same as normal payment record)

(3) Initials (same as normal payment record)

(4) Debit-Credit Code (same as normal payment record)

(5) Expense Year (same as normal payment record)

(6) Reasonable Medical Charges (Non-psychiatric). Show the amount of the total reasonable non-psychiatric charges that have been paid by the beneficiary plus any portion of the unpaid amount being credited toward the deductible.

(7) Outpatient Psychiatric Expense. Show the reasonable psychiatric expenses that have been paid by the beneficiary plus any portion of the unpaid amount being credited toward the deductible. The general limitation on outpatient psychiatric expense of the lesser of $62\frac{1}{2}$ percent or $312.50 also applies here.

(8) Deductible Applied. Show any amount of incurred expenses paid or unpaid included in the amounts shown in (6) and/or (7) above that are being applied to the deductible.

(9) Reimbursement Amount. Show 80 percent of ((6)+(7))-(8)

(10) Intermediary Control Number (same as normal payment record)

(11) Employment Relationship (same as normal payment record)

(12) PP (show the letters PP in the field normally used for physician specialty code--these letters must be present in this type of payment record)

(13) Record Mark (same as normal payment record)

B. On subsequent receipt of partially paid bill where there is no assignment (second, and third partial payments, etc.), prepare only the skeleton payment record specified in "A2" above.

Note: Extreme caution must be exercised regarding the deductible (which can be considered met out of the unpaid portion of such bills) when handling these 2nd, 3rd, etc., partial payments to assure that reimbursement is not made for deductible amounts. Possibly for the last or the last 2 bills submitted by the beneficiary in these situations, depending upon the amounts involved, no reimbursement may be involved and if not, no payment record should be prepared.

C. Some partially paid bills will fall into the "Continuous Bill Sample." For those that do, only the first one showing complete information regarding the total bill should be sent to Baltimore with the annotation next to the reimbursement amount "partial payment."

D. The batch count field of the batch control record should include the total of both types of payment records.

6532.2 Content of Payment Records for Bills for Hospital-Based Physicians (Forms SSA-1554).--Hospitals may under certain situations (as covered by instructions in the Hospital Manual and Regulations No. 5 Part 405, Subpart D-Principles of Reimbursement for Provider Costs and Services by Hospital-Based Physicians) report services furnished to patients on Form SSA-1554 under the name of department heads rather than the individual physicians actually providing the services.

Where Forms SSA-1554 are completed in this fashion, Payment Records will still be prepared in accordance with instructions in section 6528 but with the following modifications:

1. It will not be necessary to assign a separate physician identification code to each department head or department listed. The Provider Number shown in item "7" of the SSA-1554 followed by the letter "Z" (alpha) should be used as the physician identification code for all Payment Records prepared from 1554's submitted by that hospital.

2. The appropriate physician specialty code should be assigned on the basis of the department involved--e.g., code "22-pathology" for diagnostic laboratory, code "30" for radiology, etc.

3. The type of physician and board certification code will usually be code 3. However, if based on other information it can be determined that code 6 or 9 applies, use one of these codes. If it cannot be determined which of these codes to use, leave this item blank.

These modifications apply only to hospitals that bill for the physician component of services provided by hospital-based physicians under the name of the department head rather than the name of the physicians actually furnishing services.

Preparing Payment Records Prior to Transmission to SSA

6534. BATCHING PAYMENT RECORDS

It is suggested that punchcard reporting intermediaries group payment records in batches of 2,000 when preparing to transmit them to SSA. When reporting is made by magnetic tape, the entire tape may be one batch or there may be more than one batch on a tape. Where more than one batch is submitted on a tape, a header

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PART B INTERMEDIARY MANUAL

HIM-14 - Part 3

REVISION TRANSMITTAL NO. 5

New Material	Page No.	Replaced Pages
Sec. 6102.6 (Cont'd) - 6103.1 (Cont'd)	21-22	21-22

Section 6103 is modified to clarify the policy relating to coverage under Part B of services and supplies incident to physicians' professional services. The revision manualizes those portions of Intermediary Letter No. 127 which are appropriate to carrier operations.

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B. The diagnostic medical and surgical services performed in hospital outpatient departments by interns and residents-in-training not under an approved teaching program;

C. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program;

D. The medical and surgical services performed for extended care facility and home health agency patients by interns and residents (whether or not under an approved program) which are not covered under Part A.

6103. SERVICES AND SUPPLIES

Services and supplies (including drugs and biologicals which cannot be self-administered) are those furnished incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices or clinics and are commonly either rendered without charge or included in physicians' bills. (Certain hospital services are also covered as incident to physician services when rendered to outpatients. Payment for these services is made to the hospital on a reasonable cost basis by the Part A intermediary.)

"Incident to a physician's professional service" means that the services are administered as part of the physician's professional services in the course of diagnosis or treatment of an injury or illness.

A. Services and Supplies Commonly Furnished in Physicians' Offices.--Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his supervision, such as nurses, technicians, therapists and other aides. For example, if a physician employs a physical therapist and includes the charges for such services in his own bills, the services of the physical therapist are considered to be incident to the physician's services if there is direct personal supervision by the physician.

Supplies usually furnished by the physician in the course of performing his services, such as gauze, ointments, bandages, etc., are also covered. Payment for drugs and biologicals which cannot be self-administered can be made only to the physician who administers them. For example, in the case of an allergist who prepares and furnishes drugs to a patient, but does not administer them, payment can be made only to the physician who actually administers the injection. Charges for such services and supplies must be included in the physicians' bills.

If auxiliary personnel perform the services outside the office setting, their services are covered only if there is direct personal supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered; if the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician would not be providing direct personal supervision.

Services provided by auxiliary personnel not in the employ of the physician, even if provided on the physician's order (e.g., a referral to an independent practitioner for physical therapy), would not be covered under this category, since the law requires that they be of kinds that are commonly furnished in physicians' offices and commonly either rendered without charge or included in physicians' bills.

B. Services and Supplies Incident to a Physician's Service in a Clinic.--Services and supplies incident to a physician's service in a physician-directed clinic or group association are generally the same as those described in A. above. However, in highly organized clinics, particularly those which are departmentalized, "direct personal physician supervision" may be the responsibility of several physicians as opposed to an individual attending physician. In this situation medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by therapists and other aides are covered even though they are performed in another department of the clinic. Supplies provided by the clinic during the course of treatment are also covered.

When the auxiliary personnel perform services outside the clinic premises, the services are covered only if performed under the direct personal supervision of a clinic physician. If the clinic refers a patient for auxiliary services performed by personnel who are not employed by the clinic, such services would not be incident to a physician's service.

6103.1 Drugs and Biologicals.--Drugs and biologicals are covered only if they are of the type that cannot be self-administered and are generally limited to those that are administered by injection. Thus, injections would be covered even if required on a continuing basis, such as those for pernicious anemia, arthritis, etc., provided they are administered by the physician or his nurse. However, if the injection is of the type which is commonly self-administered, such as insulin, the drug or biological is excluded unless administered to the patient in an emergency situation.

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

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REVISION TRANSMITTAL NO. 6

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New Material	Page No.	Replaced Pages
Sec. 6020 (Cont.) - 6027	11-12	11-12
Sec. 6325 - 6325.2	103-104	103-104
Sec. 6415.1 (Cont.) - 6418	121-122	121-122
Sec. 6612 - 6620.1	187-188	187-188

This Revision Transmittal makes changes in sections 6020B and 6027B. All other changes shown below have already been transmitted to intermediaries by telegram.

Section 6020 - 6020A is revised to indicate that payment should not be delayed to obtain the explanation of a signatory other than the patient or his representative payee. This is a temporary change. It will be rescinded after the SSA-1490 has been revised to emphasize the need for the explanation. The first paragraph of 6020B has been deleted. When circumstances exist as set forth in that paragraph, the carrier is not presently required to ask the district office to make a possible investigation of a representative payee issue.

Section 6022 - Same revision as Section 6020A.

Section 6027 - In 6027B, the second requirement for making direct payment in nonassignment cases has been revised. There must be evidence clearly establishing incompetence or incapability to preclude payment to the beneficiary.

Section 6325.2 - Items 5-6 revised to indicate that when signature is by mark, payment may be made if the witness' name is shown, even if the address is omitted. This is a temporary change which will be in effect until the SSA-1490 is revised to point up the need for the address.

Section 6418 - The requirement in the last paragraph of a report to SSA when payment cannot be made has been eliminated. Cases should be listed or identified for possible future action.

Section 6615 - Continuous statistical sample forms should be batched by type of bill. Subsection f., Type of Bills, has been added.

Arthur E. Hess, Director
Bureau of Health Insurance

requesting payment for paid bills or assigning unpaid bills. The signature line of the request should be completed with the name of the patient followed by "By" and the representative's signature and address.

The intermediary may honor a request by someone other than the patient or his representative payee if the patient is in such physical or mental condition that he could not or should not be asked to transact business at the time. When the patient is in such a condition and the representative payee is not available to sign the request, the request may be signed by his legal guardian, relative or friend, or representative of an institution providing him care or support, or of a governmental entity providing him assistance. The requestor other than the legal guardian should attach a statement to the Request for Payment explaining his relationship to the patient and the circumstances which make it impractical for the patient to sign. If such a statement is not submitted, the intermediary should obtain the explanation from the requestor if other development is also needed. However do not delay processing the claim to obtain the explanation if nothing else prevents payment.

NOTE: The fact that such a request may be honored does not mean that payment can be made. (For discussion of who can receive payment, see § 6027.)

B. When the patient is entitled to monthly social security or railroad retirement benefits and is unable to file a request for payment on his own behalf because of alleged incompetency or incapability which is not likely to improve quickly and he does not have a representative payee, request the social security district office serving the intermediary to investigate and develop a representative payee.

6022. EXECUTION OF REQUEST FOR PAYMENT ON BEHALF OF INCAPABLE PERSON IN NON-BENEFICIARY CASES

(These cases are identified by suffixes M, M1, or T on the Health Insurance Claim Number.)

The intermediary may honor a request for payment (whether by assignment or for paid bills) by someone other than the patient if the patient is in such physical or mental condition that he should not be asked to transact business at the time. When the patient is in such a condition,

the request may be signed by his representative payee, legal guardian, relative or friend, or representative of an institution providing him care or support, or of a governmental entity providing him assistance. The requestor other than a representative payee or legal representative, should attach a statement to the request for payment explaining his relationship to the patient and the circumstances which make it impractical for the patient to sign. If such a statement is not submitted, the intermediary should obtain the explanation from the requestor if other development is also needed. However, do not delay processing the claim to obtain the explanation if nothing else prevents payment.

NOTE: The fact that such a request may be honored does not mean that payment can be made to the requestor. (For discussion of who can receive payment, see § 6027.)

6025. EXECUTION OF THE REQUEST--PATIENT DECEASED

After the death of a beneficiary, whether the request is for direct reimbursement or is an assignment, the Request for Payment must be executed by a legal representative of the deceased's estate, including any representative under a small estates statute. (See § 6418 for disposition of underpayments in death cases.)

6027. WHO MAY BE PAID BENEFITS

A. Assignment Situations.--Where a request for payment has been properly executed (see § 6018), payment may be made to the physician or supplier accepting the assignment.

B. Non-Assignment Situations.--When a request for payment has been properly executed (see § 6016), payment may be made to the beneficiary directly in non-assignment cases where:

1. A representative payee is not shown on the query reply;

2. There is no evidence that clearly establishes that the individual is incompetent or incapable; or

3. He is temporarily incapable, but his condition does not appear likely to continue indefinitely.

Where a representative payee is shown on the query reply, payment will be made to such individual. Where a representative payee is not shown on the query reply and payment may not be made to the beneficiary

6325. THE REQUEST FOR PAYMENT FORM (SSA-1490 AND 1490A)
The Request for Payment claims form (SSA-1490 and 1490A) is designed to show:

1. The name and other identifying information of the patient receiving the services or supplies.

2. The name of the person or organization providing the medical services. If not furnished by a physician, the name of the physician who prescribed the services or supplies must be shown.

3. A description of each medical and surgical procedure and any supplies furnished.

4. Each date the services were provided.

5. The charges for each medical service or item.

6. Location where the services or supplies were provided (e.g., home, office, hospital, etc.). If provided in an independent laboratory, its name and address must be shown.

7. Whether or not the illness or injury was employment-related.

6325.1 Identification Items on Form SSA-1490.--Part B Intermediary Identification Item: The intermediary may enter its name and address in the space provided in the upper left corner. The entry may be printed by the intermediary. (The intermediary number will also be shown in this space when a continuous sample bill is forwarded to the Social Security Administration, see § 6515.)

Name of Beneficiary: The beneficiary's name should be shown and should be checked against Item 5, "Signature," to assure that the bill reflects services to the proper beneficiary.

Claim Number: The claim number shown in this item should be checked for consistency with the claim number shown on the reply to the deductible status query, the reply to any status query, or the claim number used in a prior claim action. The claim number may be an indication that another carrier has jurisdiction, i.e., railroad retirement beneficiaries. The claim number should be entered on accompanying receipts or other developmental information received.

Sex: Check this item to see than an entry is made and that it is correct.

6325.2 Part I of Form SSA-1490--Claims Information.

Item 1: The patient's description of his illness or injury is used to supplement the information on itemized receipted bills in determining whether the services or supplies were covered and the charges reasonable.

Item 2: Investigate "Yes" and omitted answers on employment connection (see § 6420ff).

Item 3: Examine attached itemized receipted bills for acceptability as payment data and as meeting the same requirements as to dates and places of each service; procedures and services for each date given; diagnosis, etc.--outlined under item 7.

In some nonassignment cases, the physician or supplier may complete Part II of the form instead of attaching separate itemized receipted bills. In such cases, the form SSA-1490 must indicate the equivalent "receipted" status of the bill.

Item 4: When there is a mutual agreement with respect to assign-
Item 12: ment, blocks should be answered in the affirmative and signed by both the patient or his authorized representative and the physician or supplier. A doubtful or incomplete item, or any question relating to the proper execution of the request should be investigated in accordance with § 6010ff.

Item 5: The address is furnished to assist in necessary contact
Item 6: with the patient; to furnish him with a copy of the "Explanation of Benefits" form (and the address for the check or draft in direct payment cases) on completion of the intermediary's review actions; and in conjunction with the address of the physician, to assist the intermediary in determining whether it has jurisdiction of the claim. When the patient signs by mark, it is permissible to process the claim for payment when the witness' name is shown, but not his address.

Item 6 should also show the patient's or authorized representative's telephone number. This is provided for the intermediary's use in resolving any question arising on the claim for which expeditious contact with the signatory is desired.

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Room 4-R-3, Social Security Building
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Include any additional information that would be helpful in assessing the circumstances of the overpayment.

In all other cases where the overpayment has not been satisfied in full within 30 days after the date of the letter of explanation, the carrier should forward a report to SSA at the above address. (The only exception is when the enrollee is appealing the correctness of the intermediary's decision.) The report should give the amount and circumstances of the overpayment together with any correspondence received from the beneficiary. The intermediary will be notified of the disposition of the issue.

6415.2 Overpayment to Physician or Supplier in Assignment Situations. The intermediary should request refund of the overpayment from the physician or supplier or the overpayment may be offset against any Part B payment otherwise due the physician or supplier.

6415.3 Overpayment to Beneficiary, Physician, or Supplier Who Is Deceased.--Where overpayment has been made to a beneficiary who has since died, the amount and circumstances of the overpayment should be forwarded to the Bureau of Health Insurance, Division of Policy and Standards. Where the physician or supplier has been overpaid, the intermediary should forward a report of the overpayment and the circumstances surrounding such overpayment to the same address.

6418. UNDERPAYMENTS ARISING OUT OF DEATH SITUATIONS
Situations will occur where an individual dies after having established his right to payments under the medical insurance program and before such payment is made. In these cases, the payment of the amount due must be made to the legal representative of the individual's estate. A new Request for Payment form is not necessary. No payment should be made to some other person because he was the representative payee for the deceased and underpaid individual. If there is no legal representative, the payment cannot be made. In cases where a check is released to an individual prior to his death, no action need be taken to stop payment or cancel the check unless a protest is made or the check is returned. However, the intermediary should not knowingly issue any check in favor of an individual who has died. (An assignment made before death can be honored without consulting the legal representative.)

The intermediary should determine the identity of the legal representative of the estate in order to make proper payment. The appointment papers should be obtained. A check payable to the "estate of John Doe," would not be an appropriate disposition of the unpaid amount due. If no representative has been appointed, the intermediary should consider the possibility that a survivor or other person may qualify under a small estate statute. (Under the "small estate" statutes of many States, an individual can be appointed by a court to collect, receive, and distribute the assets of an estate not exceeding a certain size. An individual appointed under a small estate statute will be considered a legal representative for the purpose of making payments after the death of a beneficiary.)

Where an underpayment cannot be acquitted under the procedure described above, it should be listed or otherwise identified for possible future action, since consideration is being given to possible alternatives for making payment in these cases.

initiated for recovery of moneys overpaid.) Where the intermediary resolves the discrepancy, he may resubmit the payment record in another batch under a new batch number.

6612. OTHER ACTIONS AND MATERIAL
In addition to cases removed from the processing system prior to the updating of the utilization records, certain cases may be returned to the intermediary after the completion of all SSA processing. Such cases could involve requests for development or investigation of some aspect of the case or verification of certain data.

After the intermediary's action is completed, such cases should be returned to SSA as individual items and not included in the shipment of regular payment records, the cases should be clearly identified as cases not requiring processing. Generally, such cases should be returned by letter mail to the organizational component which requested the action.

6615. CONTINUOUS STATISTICAL SAMPLE FORMS
On a daily basis or a minimum of 3 times weekly all sample forms will be sent to: Social Security Administration, Bureau of Data Processing and Accounts, Civic Howard Building, 211 West Lombard Street, Baltimore, Maryland 21201.

Before shipment each of the sample forms should have the intermediary number entered in the upper left corner of the form. The forms should be blocked by type in batches of approximately 100. Any bills or other forms accompanying the Request for Payment form must be securely attached to the Request for Payment form. Each shipment of bills must be sent under cover of a transmittal, form SSA-1575. (Exhibit 2) The SSA-1575 should be prepared in duplicate with the original accompanying the shipment to SSA and the duplicate maintained by the intermediary. Enter the following information on the SSA-1575 in the appropriate spaces:

a. Intermediary identification number

b. Intermediary's name and address

c. Batch date

d. Batch number - A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. If an intermediary has more than one paying office submitting records directly to SSA, each individual office must maintain separate consecutive batch numbers for records they submit.

e. Total number of bills

f. Type of bills - Specify "SSA-1490 (1490A)" or "SSA-1554."

Files Maintenance

6620. GENERAL PROVISIONS

Subject to the provisions of the Code of Federal Regulations, Title 41, the Social Security Administration has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, the Secretary is required to provide for effective controls over the creation of records including the making of records containing adequate and proper documentation of the intermediary's administration and operations. The claims records referred to in this chapter are designated as Government records comprising Government-issued standard forms and other supporting forms needed to document claims records. Such Government forms will be developed, issued, printed, and distributed by the Social Security Administration and will be maintained by the intermediary, in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials.

Each Part B intermediary is required to establish and maintain an active continuing program for the economical and efficient management of its claims transaction records under the health insurance program. Accordingly, intermediary record programs should provide for:

(1) Effective control over the creation, the organization, maintenance, use, and disposition of all Social Security Administration health insurance claims records. Files are to be organized so that needed records can be found rapidly; complete records are insured; the selection and retention of records of value are facilitated; and the disposal of noncurrent records is accomplished with maximum economy in personnel, equipment, and supplies;

(2) Cooperation with SSA in developing and applying standards, procedures, and techniques designed to improve the management of claims records, assure the maintenance and security of records of continuing value, and facilitate the segregation and disposal of all records of temporary value.

6620.1 Files Defined.--A file is basically a paper or folder of papers, but the term is used to denote papers, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, or on shelves, and occupying office or storage space. Stocks of publications and blank forms are excluded from the definition. Specifically, the files affected by these instructions relate to transactions involved in the processing and payment of claims for services rendered to health insurance beneficiaries.

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REVISION TRANSMITTAL NO. 7

New Material	Page No.	Replaced Pages
Table of Contents, Chap. IV	95	95
Sec. 6309 - 6314	99-100	99-100

Section 6314, formerly entitled "Devices to Obtain Payment Through Deception" has been revised and is now entitled, "Fraud in Connection with Claims." This section sets forth the guides for identifying and handling claims with possible fraud implications.

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Bureau of Health Insurance

CHAPTER IV

BILL REVIEW

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Copies of Provider Services Bills	6305	97
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Charges by a Relative or Member of the Immediate Household	6309	99
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The Request for Payment Form (SSA-1490 and 1490A)	6325	103
Identification Items on Form SSA-1490.--Part B Intermediary Identification Item	6325.1	103
Part I of Form SSA-1490--Claims Information	6325.2	104
Part II of Form SSA-1490--Report of Services	6325.3	105
Provider Billing for Patient Services by Physicians (Form SSA-1554)	6330	111

determinations of reasonable charges will contain enough information to satisfy statistical needs. If, of course, a contact must be made in order to process a claim, then all missing information should be secured.

Where as a result of development undertaken by the intermediary, additional information which was needed to make a payment has been secured, the additional information should be clearly reflected in the file.

6309. CHARGES BY A RELATIVE OR MEMBER OF THE IMMEDIATE HOUSEHOLD
When the patient is charged for services by a member of the patient's household or by an immediate relative, no health insurance payment can be made. Hence, intermediaries, in reviewing Request for Payment, will have to resolve any questions that raise this issue; e.g., the surname and/or residence of the patient and that of the physician or supplier is the same. See § 6120.11 for a definition of "members of the patient's household" and "immediate relative."

6311. DUPLICATE AND/OR OVERLAPPING BILLS WITH DISCREPANT CHARGES
Occasionally, an intermediary will receive a bill which, on the basis of incurred dates or other entries on the bill or in the intermediary's file, duplicates an earlier bill except that the amount of payment which is requested varies from the services rendered or the health items furnished.

Discrepant charges may also be revealed when a later bill not only duplicates an earlier bill, but is also a Request for Payment for additional services rendered or new health items furnished.

Where such discrepant charges are discovered, the necessary development should be undertaken to ensure that the proper payment has or will be made.

Where corrections or adjustments are made after the intermediary has forwarded a payment record to the Social Security Administration, it will be necessary to prepare a corrected payment record sufficiently identified as such so that the Social Security Administration can adjust its records.

6314. FRAUD IN CONNECTION WITH CLAIMS
Section 208 of the Social Security Act, which provides penalties for fraud and misrepresentation in connection with claims for benefits, is generally applicable to the health insurance program. The procedures for processing health insurance claims should insure that payment is

made only for covered services furnished to health insurance beneficiaries; however, it is recognized that these procedures cannot be one hundred percent effective. Sanctions provided under section 208 of the Act will be applicable in any case in which it is found that a person attempted, by fraud or misrepresentation, to obtain services or payment under health insurance.

While the Social Security Administration has the responsibility for undertaking the necessary development in any case in which fraud or misrepresentation is indicated, the intermediary has a basic responsibility for recognizing possible fraudulent claims and calling them to the attention of the Social Security Administration. Where cases of fraud or misrepresentation are uncovered, the intermediary is to withhold payment to a provider, beneficiary, or other person as the case may be, until the Social Security Administration has had the opportunity to investigate the matter.

Intermediaries should be alert to recognize fraudulent claims; however, they should guard against a posture in which all claims are viewed as suspect. Fraud is expected to occur only in a very small percentage of cases. Intermediaries must distinguish between deliberate fraud and erroneous claims based on mistakes or misunderstanding of the law. It is likely that many persons have some misunderstanding of who may be entitled to benefits and what services are covered under the health insurance program.

Incidents which might possibly show indications of fraud may include claims in which the alleged services would not have been appropriate in the treatment of the illness; contacts by beneficiaries who, after receiving utilization notices, deny having received some or all of the services for which payment was made under the health insurance program; altered bills and receipts; etc. In these or similar situations, the intermediary should first verify routinely that no clerical error or genuine mistake was involved in making the claim. Where it appears that there may have been an attempt to claim benefits by fraud or misrepresentation, a report should be sent to the Social Security Administration for further investigation. These reports should be directed to the attention of the Social Security Administration, Bureau of Health Insurance, Division of Health Insurance Policy and Standards, Room 4-R-2, Baltimore, Maryland 21235.

Administration experience has shown that we can expect to receive occasional signed and unsigned allegations indicating that a particular individual received benefits to which he was not entitled. In these cases, the intermediary should limit its investigation to verifying that a claim for benefits was made by the individual as alleged, and a report, containing the facts in the case, along with the statements in evidence, should be forwarded to the Bureau of Health Insurance at the address above.

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PROVIDER REIMBURSEMENT MANUAL

U.S. DEPARTMENT OF
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SOCIAL SECURITY ADMINISTRATION

HIM-15 (7-67)
REPRINT DATE 10-69

This manual has been reprinted to incorporate all revision transmittals issued through the reprint date. It should be noted that the material contained in this reprinted manual is exactly the same as that contained in manuals being maintained by the incorporation of revision transmittals.

Copies of the reprinted manuals should not be ordered to replace older editions.

5–68 CHECK SHEET OF PROVIDER REIMBURSEMENT MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword to provide a record of Manual revisions received. Provider Reimbursement Manual revisions will be issued under cover of numbered "Revision Transmittals."

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.	4/68	21.		41.		61.		81.	
2.	6/68	22.		42.		62.		82.	
3.	3/68	23.		43.		63.		83.	
4.	11/68	24.		44.		64.		84.	
5.	11/68	25.		45.		65.		85.	
6.	2/69	26.		46.		66.		86.	
7.	6/69	27.		47.		67.		87.	
8.	6/69	28.		48.		68.		88.	
9.	6/69	29.		49.		69.		89.	
10.	8/69	30.		50.		70.		90.	
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Health Insurance for the Aged

PROVIDER REIMBURSEMENT MANUAL

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FOREWORD

This manual is for use by providers of services in computing the reasonable cost of services furnished under the provisions of the Health Insurance for the Aged Act of 1965, as amended. The procedures and methods in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries. The manual contains informational and procedural material on various aspects of the determination of cost and will assist providers in preparing annual cost reports. This manual will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished. The provider's intermediary will issue any necessary supplementary instructions as appropriate for local guidance on items relating to cost determination.

The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations.

The manual will accommodate new pages or revisions as further interpretations of the regulations and changes in procedures and methods are made. Accordingly, revised sections, pages, or chapters will be issued as necessary.

Questions by a provider on cost policies and procedures in the program should be referred to the provider's intermediary. Providers dealing directly with the Social Security Administration may refer questions on cost determinations to the Bureau of Health Insurance Regional Representative.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance

INTRODUCTION

Regulations pertaining to the medicare program set forth principles to be followed in determining the reasonable cost of provider services. These "Principles of Reimbursement for Provider Costs" have also been published in HIM–5. This manual provides guidelines and policies to be followed in implementing the cost principles. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

Under generally accepted accounting principles, or under the "Principles of Reimbursement for Provider Costs" there may be more than one method for handling a particular cost item; in such case the method elected by the provider must be consistently followed in subsequent reporting periods. A change of method must be approved by the intermediary (or SSA for providers dealing direct) on a prospective and not retrospective basis. Where the manual sets a time limit for requesting such change, or limits the number of changes, the provider and intermediary will be guided by the manual instructions.

If a provider has any question on how to determine reasonable cost, or how to apply any part of this manual in a particular situation, it should submit the question to its intermediary (or to the Social Security Administration if it deals with the Government). Answers to questions raised by some providers which may be of interest to other providers will periodically be added to the applicable chapters and sections of this manual.

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Chapter I
DEPRECIATION

100. GENERAL

The principles of reimbursement for provider costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

Three methods of prorating the cost of depreciable assets are available: straight-line, declining balance, and sum-of-the-years' digits. The method chosen for the medicare program for an asset or groups of assets need not correspond to the methods used by the provider for nonmedicare purposes.

102. PRINCIPLES

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and (c) prorated over the estimated useful life of the asset using the straight-line method or accelerated depreciation under the declining balance or sum-of-the-years' digits methods.

Depreciation on assets being used by a provider at the time it enters into the Title XVIII program is allowed; this applies even though such assets may be fully or partially depreciated on the provider's books.

With respect to all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percent to be applied is 5 percent starting with the year 1966–67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to a regular depreciation on assets acquired after 1965; however, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired or rented after 1965 may not exceed 6 percent of the provider's allowable cost for the current year.

Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

104. DEFINITIONS

Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation. The amount of depreciation is determined by the provider's method of depreciation accounting.

The American Institute of Certified Public Accountants defines depreciation as a process of cost allocation:

> "Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

104.1 Depreciable Assets.—Assets that a provider has an economic interest in through ownership —regardless of the manner in which they were acquired—are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a provider is using under a regular lease arrangement would not be subject to depreciation by the provider. (See section on Lease-Purchase and Sale-Lease-Back Agreements (§ 110).)

In general, assets subject to depreciation are de-

scribed in the AHA Chart of Accounts for Hospitals, M–58, 15M—8/66—183305, and for the most part are also subject to depreciation for medicare purposes. However, see the treatment of minor equipment as described below.

104.2 Buildings.—Building includes, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

104.3 Building Equipment.—Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (a) affixed to the building, and not subject to transfer; and (b) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

104.4 Major Moveable Equipment. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, X-ray machines, etc. The general characteristics of this equipment are: (a) a relatively fixed location in the building; (b) capable of being moved as distinguished from building equipment; (c) a unit cost sufficient to justify ledger control; (d) sufficient size and identity to make control feasible by means of identification tags; and (e) a minimum life of approximately three years.

104.5 Minor Equipment.—Minor equipment includes such items as waste baskets, bed pans, syringes, catheters, silverware, mops, buckets, etc. The general characteristics of this equipment are: (a) in general, no fixed location and subject to use by various departments of the provider's facility; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and, (e) generally, a useful life of approximately three years or less.

104.6 Land (Non-depreciable).—Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacements is not the responsibility of the provider and other land expenditures of a non-depreciable nature.

104.7 Land Improvements (Depreciable).—Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).

104.8 Leasehold Improvements. — Leasehold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

104.9 Accounting Records.—The depreciation allowance, to be acceptable, must be adequately supported by the provider's accounting records. For medicare purposes, a provider may maintain supplementary records apart from formal records, but in a manner similar to that used in maintaining formal records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical costs (or fair market value at the time of donation in the case of donated assets), the method of depreciation, and the assets' accumulated depreciation.

104.10 Historical Cost.—Historical cost is the cost incurred by the present owner in acquiring the asset and to prepare it for use. Such cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees, related legal fees.

104.11 Historical Cost, Trade-Ins.—When an asset is acquired by trading in an asset that was depreciated under the program, the cost of the new asset would be the sum of the undepreciated balance of the old asset and the cash paid or to be paid. Where the old asset was acquired by the provider before entrance into the program, and the sum of the undepreciated balance and the cost paid or to be paid exceeds the list price, the cost of the new asset will be the list price.

For assets having no historical or appraisal values assigned, the cost basis shall be the fair market value at the date of disposal of the old asset plus the sum paid but not to exceed the list price.

104.12 Appraisals.—Where historical cost records of a purchased asset are not available an appraisal of the historical cost of the asset made by a recognized expert will be acceptable for depreciation and owner's equity capital purposes. Before an appraisal is made, the provider should inform its intermediary (or the Social Security Administration if the provider is dealing directly with the Government) of the appraisal expert, and the type and method of appraisal he will use. The intermediary (or SSA) will determine whether the contemplated appraisal for determining historical cost will be acceptable.

The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal expert making the appraisal should be one who is recognized as an appraisal authority based on sufficient experience and background in determining the historical cost of used assets.

104.13 Lease-Purchase Assets.—The historical cost of such assets is the sum of the lease payments and any additional payments made to acquire the assets, excluding the amount allowed as rent during the period of the lease or rental arrangement.

104.14 Purchase of Facility As An On-Going Operation.—In establishing the historical cost of assets where an on-going facility is purchased through a bona fide sale after June 30, 1966, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of sale. If the facility was being operated under the program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report, must agree with the historical cost used by the new provider in computing depreciation.

If a purchaser cannot demonstrate that the sale was bona fide, the lesser of the seller's net book value or sale price shall be used by the purchaser as the historical cost of the asset. In such cases, the difference between the sale price and the net book value shall be considered good will. The good will so established is not amortizable.

104.15 Fair Market Value—Donated Assets.—Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition. An asset is considered *donated* when the provider acquires the asset without making any payment for it in the form of cash, property, or services. When the provider makes any such payment in acquiring the asset, then this payment, and not the fair market value, is considered to be the historical cost of the asset.

104.16 Donated Assets — Appraisals.—Where the provider's records do not contain the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

The provider should furnish its intermediary (or the Social Security Administration if the provider deals directly with the Government) with information identifying the appraisal expert, and type and method of appraisal to be used. The intermediary (or SSA) will determine whether the contemplated appraisal will be acceptable.

104.17 Useful Life of Depreciable Assets.—The depreciable life of an asset is its expected useful life to the provider; not necessarily the inherent useful or physical life. The useful life is determined in the light of the provider's experience and the general nature of the asset and other pertinent data. Some factors for consideration are: (a) normal wear and tear, (b) obsolescence due to normal economic and technological advances, (c) climatic and other local conditions, (d) provider's policy for repairs and replacement, and (e) expected or known retirement date.

Providers may utilize the useful life guidelines published by the American Hospital Association or the Internal Revenue Service. A different life may be used; however, when the life selected differs significantly from that established by the guides, it must be supported by adequate documentation. Also, a composite useful life may be used for a class or group of assets.

104.18 Useful Life, Leasehold Improvements.—The cost of improvements which are the responsibility of the provider under the terms of a lease may be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter. The term of the lease includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the

provider or in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc.; unless the provider establishes omitting past acts, that it will probably not renew, extend, or continue the lease.

104.19 Salvage Value, Depreciable Assets.—Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and except for the declining balance method, is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for $17,000 with an expected salvage value of $2,000; the basis for depreciation becomes $15,000—i.e., $17,000 less $2,000—for computing the depreciation.

Thus, if a provider disposes of its assets when they are in good operating condition, the salvage value would be higher than it might if the provider used the assets until their inherent life had been substantially exhausted.

106. METHODS FOR WRITING OFF COST OF MINOR EQUIPMENT

The original cost of the minor equipment needed to operate the provider's facility may be treated in any of the following methods:

a. The original investment in this equipment is not amortized or depreciated. Any replacements are charged to operating expense. The investment in non-amortizable equipment is adjusted periodically by increases; or

b. The inventory cost of such items at the time the provider enters the program may be written off ratably over 3 years; that is, 1/3 of the inventory cost is written off each year. Any new purchases will also be written off ratably over a 3-year period; or

c. Certain categories of equipment such as, for example, surgical instruments, may be written off ratably over their actual useful lives.

108. CAPITALIZATION OF EXPENDITURES FOR DEPRECIABLE ASSETS

Realistic standards must be set by providers in establishing the cost and useful lives of depreciable assets purchased which will be capitalized. For example, the policy of a particular provider may be to capitalize all depreciable asset expenditures of $50.00 or more when the asset has an estimated useful life of three years or longer, while asset expenditures of less than $50 would be charged to expense. The standards so established must be followed consistently. Irrespective of the policy established, depreciable assets costing $100 or more must be capitalized. Where an asset is purchased in quantity so that the cost of the quantity exceeds $200 the cost of the individual items must be capitalized.

110. SALE AND LEASEBACK AND LEASE-PURCHASE AGREEMENTS

A. *Sale and Leaseback Agreements—Rental Charges.*—Rental costs specified in sale and leaseback agreements, incurred by providers through selling plant facilities or equipment to a purchaser not connected with or related to the provider and concurrently leasing back the same facilities or equipment are includable in allowable costs if these conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;
2. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost;
3. The leasing was based on economic and technical considerations. If all these conditions are not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

B. *Lease Purchase Agreements—Rental Charges.*—Some lease agreements are essentially the same as installment purchases of facilities or equipment. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs had he had legal title to the asset, such as, for example, straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year

the asset is returned. If the asset continues to be rented after the due date for the purchase, and rental has been reduced, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair market rental value.

The existence of the following conditions will generally establish that a lease is a virtual purchase:

1. The rental charge exceeds rental charges of comparable facilities or equipment in the area,
2. The term of the lease is less than the useful life of the facilities or equipment; and
3. The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time or times acquisition by the provider is permitted.

112. ALLOWANCE FOR DEPRECIATION ON FACILITIES LEASED FOR A NOMINAL AMOUNT

A considerable number of providers lease their facilities from municipalities at a nominal rental—usually for $1.00 per year—the lease generally covering the useful life of the facility. Under most lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such case the cost of any addition or improvement would be similarly amortized and the amortization allowance would likewise be includable in allowable cost.

It is the general practice of the provider to include in its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse providers on the basis of cost allow depreciation on facilities that have been leased for a nominal rental. In view of the above and since the lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

112.1 Analysis of Lease Arrangement.—Each case must be decided on its own merits for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility. The lease may and frequently does cover the useful life of the asset; however, if the lease does not do so, such as a year to year lease, such lease should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the provider will use the facility to the extent of their useful lives. Where the intent and provisions of the year to year lease permit the provider to have the benefit of the useful life of the facility, such lease should be treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life.

The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free hospital services to the employees of the lessor, then depreciation in such case should not be allowed. In such case, the cost of the services furnished to the lessor's employees would be appropriately included when determining medicare's share of allowable costs.

Where the provider pays or contributes to the lessor any funds which are to be used for retiring the lessor's bonds or notes issued for the facility, such payments will be considered rental payments. These rental payments, to the extent they are reasonable, will be considered an allowable cost; likewise, any general contribution by the lessee to the lessor will be considered a rental payment for the use of the facility. Where either of such rental payments is allowable as cost, depreciation on the leased facility will not be an allowable cost item.

Any questions on the legal interpretation of the lease as it relates to the criteria discussed above, should be submitted through the Bureau of Health

Insurance regional office for an opinion from the regional attorney.

112.2 Basis and Method for Depreciation.—The leased asset should be treated for depreciation cost allowance purposes under the program as though the lessor and lessee were one and the same. All the cost principles and reimbursement manual sections on depreciation would be applicable to such assets. For example, the basis for depreciation will be the historical cost of the asset to the lessor adjusted for past depreciation; and if historical cost records are not available, a proper appraisal for establishing the historical cost would be acceptable. Where the leased facility is later purchased by the provider, the facility's undepreciated balance on the date of title transfer or the purchase price, whichever is lower, will for further depreciation purposes be considered the unrecovered cost of the facility.

The following illustration demonstrates how depreciation would be computed on the leased facility and amortization on improvements made to that facility.

Facts

Historical cost of the leased facility at acquisition date—7/1/56	$520,000
Estimated salvage value	$ 20,000
Estimated useful life of the facility	40 years
Life of the lease effective at 7/1/60	35 years
Method for depreciation	Straight line
Leasehold improvement 7/1/65	$ 90,000
Estimated useful life of improvement	30 years

Computation of Depreciation

Historical cost of building	$520,000	
Less: Estimated salvage value	20,000	
Basis for depreciation	$500,000	
Annual rate of depreciation based on 40 year life	2.5%	
Annual depreciation on building		$ 12,500
Accumulated depreciation on 7/1/66* (10 years @ $12,500)		$125,000

Computation of Amortization on Improvement

Cost of leasehold improvement	$ 90,000	
Useful life—30 years		
Annual amortization	$ 90,000 ÷ 30 years	$ 3,000
Accumulated amortization on 7/1/66 *		$ 3,000

Total Annual Depreciation and Amortization

Annual depreciation on facility	$ 12,500
Annual amortization on improvement	3,000
Total	$ 15,500

* Date of entrance into medicare program.

114. BASIS FOR DEPRECIATION

A. *New Assets.*—The basis for depreciation of new assets under the straight-line and sum-of-the-years digits methods is the historical cost of the asset (or fair market value in the case of donated assets) less its salvage value. Under the declining balance method, the basis for depreciation is the historical cost only.

B. *Used Assets—Partially or Fully Depreciated on the Providers' Books.*—The adjusted historical cost of the asset as determined below is to be used for determining the basis for depreciation under the three approved methods for depreciation. For the straight-line and sum-of-the-years' digits methods, the basis for depreciation would be the adjusted historical cost reduced by the estimated salvage value. Where the declining balance method is used, the basis for depreciation would be the adjusted cost of the asset.

The adjusted historical cost of an asset that is in use when the provider enters the program is its historical cost reduced by the depreciation accumulated up to the date of entrance into the program. Accumulated depreciation for this purpose may be determined on a straight-line basis (regardless of the depreciation method used or in use by the provider) and based on an estimate of the asset's useful life taking into account past and current information. Thus, if an asset currently in use has been fully depreciated on the provider's books it would be evident that an asset's useful life has not ended. Consequently, a new estimate of the asset's useful life, based on current information, may be made.

The following examples illustrate how the basis for depreciation is determined for used assets:

Facts

Historical cost of the asset	$25,600
Estimated salvage value	$ 1,600
Asset acquired on July 1, 1962.	
Original estimated useful life is eight years.	
On July 1, 1966, the asset's useful life is estimated to be twelve years from date of acquisition.	

1. *Provider had previously used straight-line method for depreciation—Assets partially depreciated*

Accumulated depreciation on the books		$12,000
Accumulated depreciation for medicare purposes:		
Historical cost		$25,600
Estimated salvage value		1,600
Basis for computing accumulated depreciation		$24,000
Adjusted accumulated depreciation (4/12 x $24,000)		8,000
Adjusted historical cost:		
Historical cost		$25,600
Less: Adjusted accumulated depreciation		8,000
Adjusted historical cost		$17,600
Basis for depreciation under the program:		
Declining balance method of depreciation:		
(Adjusted historical cost)		$17,600

Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

2. *Provider had previously used sum-of-the-years' digits for depreciation—Assets partially depreciated*

Accumulated depreciation on the books	$17,333
Accumulated depreciation for medicare purposes:	
Historical cost	$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	$24,000
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x $24,000)	$ 8,000
Adjusted historical cost:	
Historical cost	$25,000
Less: Adjusted accumulated depreciation	8,000
Adjusted historical cost	$17,600
Basis for depreciation under the program:	
Declining balance method (Adjusted historical cost)	$17,600
Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

3. *Provider had previously used declining balance method—Asset partially depreciated*

Accumulated depreciation on the provider's books	$17,500
Accumulated depreciation for medicare purposes:	
Historical cost	$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	$24,000
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x $24,000)	$ 8,000
Adjusted historical cost:	
Historical cost	$25,600
Less: Adjusted accumulated depreciation	8,000
Adjusted historical cost	$17,600
Basis for depreciation under the program:	
Declining balance method (Adjusted historical cost)	$17,600
Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

116. DEPRECIATION METHODS

Three methods are acceptable for computing depreciation, namely the straight-line, sum-of-the-years' digits, and declining balance methods. However, the accelerated methods of depreciation—sum-of-the-years' digits and declining balance may be used only if the assets' expected useful life under the program is more than three years. Regardless of the method of depreciation being used, an asset should not be depreciated below its salvage value. (See § 104.19 on Salvage Value.) No additional first year bonus depreciation is allowable. A provider may elect any one of the three acceptable methods. A formal election procedure is unnecessary for depreciable assets held at the time of entrance in the program or for assets subsequently acquired. The depreciation method used in claiming depreciation on a particular asset for the first time will be presumed to be the depreciation method selected for that asset. A provider need not use the same method for all depreciable property. Also, a provider may elect to use a different depreciation method for similar property acquired later. However, if a provider wishes to change methods, a formal request and approval by the fiscal intermediary will be necessary as explained under the "Change of Depreciation Method" section.

116.1 Straight-line Method.—Under this method the annual allowance is determined by dividing the cost of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year. The following examples illustrate how depreciation is computed:

NEW ASSET

Facts:	Acquisition cost	$17,000
	Estimated salvage value	2,000
	Estimated useful life	5 years

Annual depreciation is computed as follows:

Acquisition cost	$17,000
Less: Estimated salvage value	2,000
Basis for depreciation	$15,000

$$\frac{\text{Basis for depreciation}}{\text{Useful Life}} = \text{Depreciation per annum}$$

$$\frac{\$15,000}{5 \text{ years}} = \$3,000 \text{ each year}$$

The annual allowance can also be computed by using a percentage applied to the basis for depreciation. For example, in the above illustration, a five year life produces a 20% rate (100%/5 years). This 20% rate when applied to the $15,000 basis for depreciation results in an annual $3,000 depreciation allowance for each of the five years.

USED ASSET

Facts:	Historical cost	$46,000
	Salvage value	1,000
	Estimated useful life	15 years
	Years asset used by provider before entrance into program	10 years
	Straight-line method of depreciation to be used for medicare purposes.	

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the basis for depreciation as follows:

Cost	$46,000
Deduct: Salvage value	1,000
Balance	$45,000

Deduct: Accumulated depreciation under the straight-line method for 10 years

$$\frac{(10 \text{ years} \times \$45{,}000)}{15 \text{ years}} = \$30{,}000$$

Basis for depreciation ---------- $15,000

c. Divide the basis for depreciation by the number of years of remaining life:

$$\frac{\text{Item b}}{\text{Item a}} = \frac{\$15{,}000}{5 \text{ years}} = \$3{,}000 \text{ annual depreciation}$$

116.2 Sum-of-the-years' Digit Method.—Under this method, the annual depreciation allowance is computed by multiplying the basis for depreciation (cost less estimated salvage value) by a constantly decreasing fraction. The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year and the denominator represents the sum of the years of estimated useful life at the time of acquisition in case of new assets or at time of entrance into the program in the case of used assets. The following example illustrates how depreciation is computed.

NEW ASSET

Facts: Cost ---------- $17,000
Estimated salvage value ---------- 2,000
Estimated useful life ---------- 5 years

Depreciation is computed as follows:

a. Add each number in the estimated useful life (5 years: $1 + 2 + 3 + 4 + 5 = 15$).
b. Use the sum 15 as the denominator of the fraction.
c. Each year, for the numerator of the fraction use the remaining years of useful life including the year for which depreciation is taken. This means using each number in a. above in inverse order (5,4,3,2,1) i.e., 5 for the first year, 4 for the second year. 3 for the third year, etc.
d. Multiply the basis for depreciation by this fraction ($\frac{c}{b}$)

Cost ---------- $17,000
Salvage ---------- 2,000
Basis for depreciation ---------- $15,000

Annual Computation

Year	*Basis for Depreciation*	*Ratio*	*Annual Depreciation Allowance*
1st	$15,000	× 5/15 =	$5,000
2nd	15,000	× 4/15 =	$4,000
3rd	15,000	× 3/15 =	$3,000

USED ASSET

Facts: Cost ---------- $46,000
Salvage value ---------- 1,000
Estimated useful life ---------- 15 years
Provider used the asset (prior to entrance into the program) for ---------- 10 years

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).
b. Add each number of the remaining years of useful life ($5 \text{ years} = 1 + 2 + 3 + 4 + 5 = 15$).
c. Use the sum 15 as the denominator of the fraction.
d. Each year, for the numerator of the fraction use the remaining years of useful life including the year in which depreciation is taken. This means using each number in (b) above in inverse order (5,4,3,2,1), i.e., 5 for the first year under the program, 4 for the second year under the program, 3 for the third under the program, etc.
e. Determine the basis for depreciation as follows:

Cost ---------- $46,000
Deduct: Salvage value ---------- 1,000
Balance ---------- $45,000
Deduct: Accumulated depreciation under straight-line method for 10 years

$$(\$45{,}000 \times \frac{10 \text{ yrs.}}{15 \text{ yrs.}}) \quad \$30{,}000$$

Basis for depreciation ---------- $15,000

f. Multiply the basis for depreciation (e) by the fraction ($\frac{d}{c}$) to determine annual depreciation.

Annual Computation

Year	*Basis*	*Ratio*	*Annual Depreciation Allowance*
1st	$15,000	× 5/15 =	$5,000
2nd	$15,000	× 4/15 =	$4,000
3rd	$15,000	× 3/15 =	$3,000

116.3 Declining Balance Method.—Under this method the annual allowance is computed by multiplying the undepreciated balance of the asset each year by a uniform rate up to double the straight-line rate. Salvage value is not considered in computing the depreciation allowance. However, under this method, the asset should not be depreciated below the estimated salvage value.

NEW ASSET

Facts: Cost ---------- $17,000
Salvage value ---------- 2,000
Estimated useful life ---------- 5 years
Rate to be used ----------Double the straight-line rate: $2 \times 20\% = 40\%$

Annual Depreciation is computed as follows:

Year	*Undepreciated Balance*	*Rate*	*Annual Depreciation Allowance*
1st	$17,000	× 40% =	$6,800
2nd	10,200	× 40% =	$4,080
3rd	6,120	× 40% =	$2,448

USED ASSETS

Facts: Cost ---------- $46,000
Salvage value ---------- 1,000
Estimated useful life ---------- 15 years
Provider used the asset (prior to entrance into the program) ---------- 10 years
Double the straight-line rate to be used under the program.

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life. (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the straight-line rate for the remaining years of useful life ($\frac{100\%}{5 \text{ yrs.}} = 20\%$).

c. Double the straight-line rate ($2 \times 20\% = 40\%$).

d. Determine the basis for depreciation as follows:

Cost	$46,000
Deduct: Salvage value	1,000
Balance	$45,000
Deduct: Accumulated depreciation under straight-line method for 10 years $45,000 \times \frac{10 \text{ years}}{15 \text{ years}}$	$30,000
Balance	$15,000
Salvage value	1,000
Basis for depreciation (or unrecovered cost in first year under the program)	$16,000

e. Multiply each year's undepreciated balance (or unrecovered cost) by 40% (Note: Do not depreciate the asset below its salvage value).

Year	*Undepreciated Balance*		*Rate*	*Annual Allowance Depreciation*
1st	$16,000	×	40%	$6,400
2nd	$ 9,600	×	40%	$3,840
3rd	$ 5,760	×	40%	$2,304
4th	$ 3,456	×	40%	$1,382
5th	$ 2,074	×	40%	$ 830

116.4 Comparison of Depreciation Methods.

A comparison of annual depreciation under each of the three acceptable methods of computing depreciation is reflected in the following table. (Salvage value at the end of the fifth year is $2,000):

	Straight-line		***Sum-of-the-years' Digits***		***Double Declining Balance***	
Rate:	—20%		(5/15, 4/15, 3/15, etc.)		(40%)	
Year	Undepreciated Balance	Annual Allowance	Undepreciated Balance	Annual Allowance	Undepreciated Balance	Annual Allowance
	$17,000		$17,000		$17,000	
	—2,000	(Salvage Value)	—2,000	(Salvage Value)	—0	(No Salvage Value)
1st	$15,000	$ 3,000	$15,000	$ 5,000	$17,000	$ 6,800
2nd	12,000	3,000	10,000	4,000	10,200	4,080
3rd	9,000	3,000	6,000	3,000	6,120	2,448
4th	6,000	3,000	3,000	2,000	3,672	1,469
5th	3,000	3,000	1,000	1,000	2,203	203*
		$15,000		$15,000		$15,000

* Although depreciation at 40% of the undepreciated balance would amount to $881, this amount cannot be used because an asset cannot be depreciated below its salvage value, and $881 would bring the undepreciated balance below salvage value ($2,000). Instead, however, the amount of depreciation to be taken for the fifth year would be the amount that would bring the undepreciated balance to the salvage value:

Undepreciated balance at beginning of 5th year	$2,203
Maximum depreciation for 5th year	203
Undepreciated balance at end of 5th year equal to salvage value	$2,000

118. DETERMINING DEPRECIATION IN YEAR OF ACQUISITION AND DISPOSAL

The amount of depreciation recorded during the year of acquisition and year of disposal varies among providers. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the intermediary. Whatever method is adopted, it must be applied to all assets subsequently acquired.

A. *Time Lag Alternatives.*—These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain extended time intervals.

1. Up to 6 Months Time Lag—Assets acquired during the first 6 months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year.

 Assets acquired during the second 6 months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year.

 Depreciation on disposal is based on the portion of the year in which the asset is disposed. If the asset is disposed of in the first half of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year a full year's depreciation is taken.

2. Up to One Year Time Lag—Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

 Note: A variation of the above methods by use of a quarterly or monthly basis for determining depreciation in the first year and the year of disposal, would be acceptable.

B. *Half Year Depreciation.*—One half year depreciation is taken in the year of acquisition regardless of acquisition date and one half year depreciation is taken on disposition regardless of disposition date.

C. *Actual Time Depreciation.*—Depreciation for the first reporting period is based on the length of time

from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed to the date of disposal.

120. CHANGE OF DEPRECIATION METHOD

Generally, a provider will adhere to the particular depreciation method or methods selected initially until final depreciation of the asset. After the initial selection, a provider may change only once to any of the other allowable methods, provided advance approval has been obtained from the intermediary. A request for change in the depreciation method must be made no later than the last day of the first month of the accounting year in which the new method is to be employed.

If the new method of depreciation is the straight-line or sum-of-the-years' digits, the basis for depreciation will be the undepreciated balance (unrecovered cost) reduced by the salvage value. If the new method of depreciation is the declining balance, the basis for depreciation will be the undepreciated balance (un recovered cost).

The new basis for depreciation will be treated as though it were the basis for depreciation of a new asset, and depreciation would be based on the remaining years of useful life. (In this respect see computation of depreciation on "used" assets under the particular method of depreciation.)

122. CHANGING ESTIMATED USEFUL LIFE

A. *Assets Acquired after Provider's Entrance into the Program.*—When the estimate of the useful life of such an asset is changed, the undepreciated balance as of the date of change is depreciated over the new remaining useful life. The following examples illustrate how the new annual depreciation is computed under the *accelerated* methods of depreciation.

EXAMPLE #1—*Declining balance method.*

An asset costing $10,000, and having an estimated useful life of 10 years has been depreciated for 6 years at the declining balance rate of 20%. The depreciation accumulated during the 6 years is $7,378.60, and the undepreciated balance is $2,621.40.

At the end of the sixth year, it is determined that the remaining useful life is 8 years. Accordingly, future depreciation must be computed as though the estimate of useful life was originally determined to be 14 years. The applicable depreciation rate would be 14⅔% (twice straight-line rate of 7⅓%). This rate would be applied to the undepreciated balance. Thus, for the 7th year the depreciation would be 14⅔% times $2,621.40—or—$374.49.

EXAMPLE #2—*Sum-of-the-years' digits method.*

An asset having an estimated useful life of 10 years is purchased for $10,500. Salvage value is estimated at $500. After five years the accumulated depreciation under the sum-of-the-years' digits method amounts to $7,272.70; the undepreciated balance of the cost is $3,227.30. At the beginning of the sixth year it is determined that the asset has 9 years more of useful life.

Depreciation for the sixth year should be computed as though the sixth year were the first year of life on an asset estimated to have a useful life of 9 years. Accordingly, the depreciation for the sixth year (or first year under the new estimate) would be computed as follows:

Basis for depreciation:	
Unrecovered cost	$3,227.30
Less: Salvage value	500.00
Basis for depreciation	$2,727.30
Sum-of-the-years' digits (1+2+3, etc . . . +9) =	45
Depreciation = 9/45 × $2,727.30 =	$ 545.46

B. *Assets Acquired before Provider's Entrance into the Program.*—Where a change is made in the estimate of the useful life of an asset that was acquired before the provider's entrance into the program, it will be necessary to correct prior year's depreciation for both the periods before and after entrance into the program. The following example illustrates how the correction is computed.

EXAMPLE

Facts:

Asset acquired 3 years before entrance into program.	
Historical cost of the asset	$30,500
Estimated remaining useful life at entrance into program	7 years
Estimated salvage value	$ 500
Straight-line depreciation used under the program.	
At beginning of 5th year under the program it is estimated that the asset has 8 more years of useful life.	

Computation of depreciation for the 5th year under the program

New estimated useful life	15 years
3 years before the program	
4 years under the program	
8 years more useful life	
15 years of useful life	
Historical cost	$30,500
Depreciation accumulated prior to program	
3 years × ($30,500–$500 salvage value) / 15 years	6,000

Adjusted historical cost	$24,500
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	$24,000
Annual depreciation under the program $\frac{\$24,000}{12 \text{ years of useful life under program}} =$	$ 2,000
Depreciation for the fourth year and annually thereafter is	$ 2,000
Correction of prior years' depreciation	
Original estimated useful life	10 years
Historical cost	$30,500
Depreciation accumulated prior to program on basis of estimate of 10 years' useful life $3 \text{ years} \times \frac{(\$30,500-\$500)}{10 \text{ years}} =$	9,000
Adjusted historical cost	$21,500
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	$21,000
Depreciation that was taken under the program in four years $4 \text{ years} \times \frac{\$21,000}{7 \text{ years}}$	$12,000
Corrected depreciation for four years under the program based on estimated useful life of 15 years (4 years × $2,000 annual depreciation)	8,000
Reduction of prior years' depreciation under the program	$ 4,000*

* Reduction of $4,000 must be applied to current year's depreciation.

124. OPTIONAL ALLOWANCE FOR DEPRECIATION BASED ON A PERCENTAGE OF OPERATING COST

For all depreciable assets acquired before January 1, 1966, the provider, at its option, may at the time it enters the program choose an allowance for depreciation based on a percentage of operating costs. This option is available to any provider, regardless of whether or not the provider has historical cost records of these assets. However, a provider that has elected to use actual depreciation cannot at a later date switch to the optional allowance.

The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percentage to be applied is 5 percent for all reporting periods beinning in the year 1966–67 (July 1, 1966—June 30, 1967); 4½ percent for all reporting periods beginning in the year 1967–68 (July 1, 1967—June 30, 1968), with such percentage being uniformly reduced by one-half percent each succeeding year.

The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965. However, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965, and the estimated depreciation on a straight-line basis on all rented assets used during the current year may not exceed 6 percent of the provider's adjusted allowable cost for the current year. In applying this limitation, if the actual depreciation claimed on post-1965 assets is on an accelerated basis, it must be converted to a straight-line basis only for use in computing this limitation. The actual depreciation claimed on an accelerated basis is properly includable in allowable costs.

124.1 Definitions.—

A. *Operating Costs.*—Operating costs are the total costs, related to patient care, incurred by the provider in operating the institution or facility.

B. *1965 Operating Costs.*—1965 Operating costs are the provider's operating costs incurred in the provider's fiscal year beginning in the period 8/1/64—7/31/65 without adjustment to medicare's principles of reimbursement for provider costs. When the 1965 operating costs are used as a base for determining the optional allowance for depreciation, such costs must be adjusted to exclude the estimated depreciation on rented depreciable type assets or the rental charge for such assets whichever is lower; and in addition, the 1965 operating cost must not include any actual depreciation, an amount in lieu of specific recognition of other costs, "a plus factor," or return on equity capital.

C. *Allowable Costs.*—Allowable costs are those costs includable in cost reimbursement under the medicare principles of reimbursement for provider costs. When the current year's allowable costs are used as a base for the optional allowance for depreciation, they should be adjusted to exclude (1) any actual depreciation, (2) the lesser of rental charges or estimated depreciation on rented depreciable type assets, (3) allowance in lieu of specific recognition of other costs, and (4) return on equity capital. The exclusion of these four items is only for the purpose of computing the optional allowance for depreciation. For other purposes, rental charges and excluded items (1), (3), and (4) are recognized in determining allowable costs and for computing the costs of services rendered to the program beneficiaries during the reporting period.

Where a provider files a short-period report, the allowable costs must be converted to a full year's basis (see example 3) only for the purpose of computing the optional allowance.

124.2 Applicable Percentages.—The percentage to be applied in each reporting year is shown in the following schedule:

Reporting year beginning *After*	but *Before*	*Percentage Allowance*
-------	7/1/67	5
6/30/67	7/1/68	4½
6/30/68	7/1/69	4
6/30/69	7/1/70	3½
6/30/70	7/1/71	3
6/30/71	7/1/72	2½
6/30/72	7/1/73	2
6/30/73	7/1/74	1½
6/30/74	7/1/75	1
6/30/75	7/1/76	½
6/30/76	7/1/77	0

124.3 Computation of Optional Allowance for Depreciation.—The following illustrates the determination of the optional allowance for depreciation based on operating costs:

EXAMPLE 1

Facts:

The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current year's allowable cost has been adjusted to remove any allowance in lieu of specific recognition of other costs and return on equity capital.

Computation

First Reporting Period (1/1/66–12/31/66)

Adjusted current year's allowable cost -------	$1,100,000
Operating cost for 1965 [1] ----------	$1,000,000
Percent for determining the allowance --------	5%
Allowance (5% × $1,000,000) ----------	$ 50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

Second Reporting Period (1/1/67–12/31/67)

Adjusted current year's allowable cost --------	$1,200,000
Operating cost for 1965 [1] ----------	$1,000,000
Percent for determining the allowance [2] ------	5%
Allowance (5% × $1,000,000) ----------	$ 50,000

[1] 1965 operating cost was used in computing the allowance for depreciation because it was lower than 1967 adjusted allowable cost.

[2] Since the reporting period began during the year 1966–67 (July 1, 1966–June 30, 1967) 5 percent is the percentage to be used.

Third Reporting Period (1/1/68–12/31/68)

Operating cost for 1965 ----------	$1,000,000
Current year's adjusted allowable cost [1] -------	$ 900,000
Percent for determining the allowance [2] ------	4½%
Allowance (4½% × $900,000) ----------	$ 40,500

[1] The current year's adjusted allowable cost was used in computing the allowance for depreciation because it was lower than 1965 operating cost.

[2] Since the reporting period began during the year 1967–68 (July 1, 1967–June 30, 1968) 4½ percent is the percentage to be used.

EXAMPLE 2

Facts:

The provider keeps its records on a *calendar year basis.* The current year actual allowable cost and the actual operating cost for 1965 did not include any actual depreciation, nor return on equity capital. However, both 1965 and the current year's costs have been adjusted to exclude depreciation ($3,000 for 1965, $2,000 for the current year) on rented depreciable type assets. The current year's allowable cost has also been adjusted to remove the allowance in lieu of specific recognition of other costs and return on equity capital.

Computation

First Reporting Period (1/1/66–12/31/66)

Adjusted current year's allowable cost -------	$1,100,000
Adjusted operating cost for 1965 [1] ----------	$1,000,000
Percent for determining the allowance --------	5%
Allowance (5% × $1,000,000) ----------	$ 50,000
Less: Estimated depreciation for depreciable type assets on which rental of $5,000 is paid in 1966 ----------	$ 3,000
Adjusted allowance ----------	$ 47,000

[1] 1965 adjusted operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

EXAMPLE 3

Facts:

The provider keeps its records on a calendar year basis. The provider's first report will be a short period one of six months, July 1, 1966–December 31, 1966. The current year's actual allowable cost and the actual operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current year's allowable cost has been adjusted to remove the allowance in lieu of specific recognition of other costs.

Computation

First Reporting Period (7/1/66–12/31/66)

Adjusted current year's allowable cost (6 months) ----------	$ 575,000
Adjusted current year's allowable cost converted to a 12-month period (2 × $575,000) -	$1,150,000
Operating cost for 1965 [1] ----------	$1,000,000
Percent for determining allowance ----------	5%
Allowance (5% × $1,000,000) ----------	$ 50,000

[1] 1965 operating cost was used in computing the allowance for depreciation because it was lower than the adjusted allowable costs covering a 12-month period.

Second Reporting Period (1/1/67–12/31/67)

Adjusted current year's allowable cost --------	$1,200,000
Adjusted operating cost for 1965 [1] ----------	$1,000,000
Percent for determining the allowance -------	5%
Allowance (5% × $1,000,000) ----------	$ 50,000
Less: Estimated depreciation for depreciable type assets on which a rental of $5,000 is paid in 1967 ----------	3,000
Adjusted allowance ----------	$ 47,000

[1] 1965 adjusted operating cost was used in computing the allowance for depreciation because it was lower than the 1967 adjusted allowable costs.

124.4 Limitation.—The optional allowance only —not the actual depreciation—is subject to a limitation based on the provider's total allowable operating cost for the current year. To determine this limitation, compute the sum of (a) the actual depreciation

claimed for post-1965 assets computed on a straight-line basis, (b) "the optional allowance based on a percentage of operating costs," and (c) estimated depreciation on depreciable type rented assets used in the current year. If this sum exceeds 6 percent of the provider's current year's adjusted allowable cost (allowable cost reduced by any depreciation claimed, the estimated depreciation on rented depreciable type assets, alowance in lieu of specific recognition of other costs, and return on equity capital), the optional allowance for depreciation must be reduced by the amount of the excess. In applying this limitation if the actual depreciation is on an accelerated basis, it must be converted to a straight-line basis *only* for use in calculating this limitation.

Where the provider files a short-period report, the period's allowable costs, after adjustment to exclude the 4 items mentioned above, must be converted to a full year's basis (see Example 3). Thus if the short-period report is for 8 months, the adjusted allowable costs should be increased by 50%; if the short period is for 9 months, the adjusted allowable cost should be increased by 33⅓%, etc. In addition, the actual depreciation computed on a straight-line basis as well as the estimated depreciation on rented depreciable type assets must be converted to a 12-month or full year's basis.

The following illustration demonstrates how the limitation is determined:

EXAMPLE 4

Facts:

The provider keeps its records on a calendar year basis. For its first report, the provider will use a 6 month's period. The current year's actual allowable cost and the actual operating cost for 1965 have been adjusted to exclude actual depreciation, the estimated depreciation on rented depreciable type assets, allowance in lieu of specific recognition of other costs, and return on equity capital.

Adjusted operating cost for 1965	$1,000,000
Adjusted allowable operating cost for the last 6 months of 1966	$ 550,000
In 1966, assets were acquired which produced for 1966 a straight-line depreciation of	$ 18,000
Estimated depreciation for the year on rented assets used in 1966	$ 4,000
Estimated annual depreciation on assets rented for which an annual rental of $5,000 is paid	$ 3,000

Computation of the Optional Allowance

First Reporting Period (7/1/66–12/31/66)

Adjusted allowable costs for the last 6 months of 1966 *converted to* a 12 month basis (2 × $550,000)	$1,100,000
Gross optional allowance: 5% of adjusted 1965 operating cost ($1,000,000) [1]	$ 50,000
Less: Estimated depreciation on assets rented	3,000
Gross allowance	$ 47,000
Add: Estimated depreciation for the year on rented assets used in 1966	4,000
Straight-line depreciation on post-1965 assets for 12 months	18,000
Total	$ 69,000
6% of adjusted 1966 allowable operating cost (6% × $1,100,000)	66,000
Deduction in allowance	$ 3,000
Gross Allowance	$ 47,000
Less: Reduction for excess of 6% limitation	3,000
Net optional allowance for the year	$ 44,000
Net optional allowance converted to a 6 month period ($44,000 ÷ 2)	$ 22,000

[1] The adjusted 1965 operating cost is used because it is lower than the adjusted allowable cost converted to a 12 months' period.

Second Reporting Period (1/1/67–12/31/67)

Facts:

Adjusted allowable cost for 1967	$1,150,000
Adjusted operating cost for 1965	1,000,000
Percent for determining the allowance	5%
Straight-line depreciation on assets acquired after 1965	$ 20,000
Estimated depreciation on $7,000 rental of depreciable type assets used in 1967	4,000
Estimated depreciation on depreciable assets rented on which annual rental of $5,000 is paid	3,000

Computation:

Gross Optional Allowance

5% times adjusted 1965 operating cost (5% × $1,000,000)	$ 50,000
Less: Estimated depreciation on depreciable assets rented	3,000
Adjusted allowance	$ 47,000
Add: Straight-line depreciation on post-1965 assets	20,000
Estimated depreciation on depreciable rented assets used in 1967	4,000
Total	$ 71,000
Less: 6% of adjusted 1967 allowable operating cost	$ 69,000
Deduction to adjusted allowance	$ 2,000
Net allowance to be included in allowable cost:	
Adjusted allowance	$ 47,000
Less: Deduction to adjusted allowance	2,000
Net allowance	$ 45.000

126. CHANGE FROM OPTIONAL ALLOWANCE TO ACTUAL DEPRECIATION

A provider that elects the optional allowance for depreciation may at any time before 1976 change to actual depreciation on its pre-1966 assets. When a provider switches to actual depreciation it can no longer elect the optional allowance.

When a provider changes to actual depreciation, the

depreciation accumulated to the date of change will be determined in the same manner as accumulated depreciation is determined for used assets when a provider enters the program. Upon disposition of the asset, the determination of gain or loss will be made on the basis of historical cost depreciation for the actual useful life of the asset.

128. ESTIMATED DEPRECIATION PENDING APPRAISAL

For those providers not wishing to use the optional method of depreciation and who have signed contracts to have appraisals made to establish the cost of pre-1966 assets, a reasonable estimate of the actual depreciation may be made, pending completion of the appraisal. Such an appraisal must be completed within two years of the contract date. Until the appraisal is completed an estimated depreciation may be taken for the current cost report, with a retroactive adjustment to the estimated depreciation to be made when the appraisal is completed.

128.1 Limitation.—The estimated depreciation may not exceed 5 percent of 1965 operating costs or the current year's allowable costs, as adjusted for computing the optional allowance for depreciation, whichever is lower. The total alowable estimated depreciation is also subject to an adjustment based on the provider's adjusted allowable cost for the current year. To determine this limitation, compute the sum of (a) the actual depreciation claimed for post-1965 assets determined on a straight-line basis, (b) estimated depreciation on rented depreciable type assets used in the current year, and (c) the estimated deprciation on pre-1966 assets. If this sum exceeds 6 percent of the provider's adjusted current year's allowable cost (allowable cost exclusive of any depreciation claimed, estimated depreciation on rented depreciable type assets, allowance in lieu of specific recognition of other costs and return on owner's equity capital), the reasonable estimated depreciation must be reduced by the amount of the excess.

When the appraisal has been completed, actual depreciation must be computed for the year(s) in which estimated depreciation was taken and compared with the amount of depreciation claimed on the cost report(s). The provider may either submit amended cost report(s) for the year(s) in question or it may adjust the current year's depreciation to reflect the difference between the estimated depreciation and depreciation based on the appraisal of the asset's historical cost. Any current year adjustment must reflect the medicare percentages of participation for the year(s) in question applied to the difference between the estimated depreciation and depreciation based on the appraisal.

130. DISPOSAL OF ASSETS

Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed.

Where an asset has been retired from active service, but is being held for stand-by or emergency services, depreciation may continue to be taken on such assets. However, where the asset has been permanently retired or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

132. GAINS AND LOSSES ON DISPOSAL OF DEPRECIABLE ASSETS

Gains and losses on the disposition of depreciable assets are includable in computing allowable costs. However, gain on the disposal of an asset must not exceed the depreciation accumulated for that asset under the program.

If the gains or losses on the disposal of depreciable assets in a reporting period are greater than ten percent (10%) of the total allowable depreciation for the period, the amount of the excess gain or loss over the ten percent (10%) must be carried forward over the five succeeding years. The identity of the gain or loss carry-forward for each individual year must be maintained in the records. The carry-forward must be considered first in determining the ten percent limitation for the current year.

132.1 Computation of Gain or Loss on Assets Acquired Before the Provider's Entrance into the Program.—When an asset that was acquired before entrance into the program is disposed of, a correction of prior years' depreciation based on *actual* useful life must be made before determining any gain or loss. The actual useful life will cover the period from date of acquisition to date of disposal. The depreciation accumulated before and after entrance into the program must be corrected in the same manner as when making a new estimate of the asset's useful life. (See § 122) The gain or loss is the difference between the amount received for the disposed asset and the corrected undepreciated cost at

the time of sale. However, where an asset is traded-in for another asset there will be neither a gain nor loss on the disposition. (See § 104.11 for determining the cost of new asset when a trade-in is involved.)

The following example illustrates how to compute gain or loss on disposal of an asset that was acquired before entrance into the program:

EXAMPLE

Facts:

Asset acquired 10 years before entrance into the program	10 years
Estimated remaining useful life at entrance into program	20 years
Total useful life	30 years
Estimated Salvage Value	$ 10,000
Historical cost	$310,000
Salvage Value	10,000
Sum-of-the-years' digits method of depreciation used under the program	$300,000
Accumulated depreciation before entrance into program (using straight-line depreciation)	100,000
Undepreciated balance subject to depreciation under the program	$200,000
Asset sold at the end of the 15th year under the program for	$ 1,000
Depreciation accumulated under program for 15 years	$185,714

Computation of Gain or Loss

Historical cost	$310,000
Corrected accumulated depreciation upon entering program—	
$10 \text{ years} \times \frac{\$300,000}{25 \text{ years}} =$	120,000
Undepreciated balance subject to depreciation under the program	$190,000
Less: Estimated salvage value	10,000
Basis for depreciation—also, total depreciation allowable under the program	$180,000

Historical cost		$310,000
Accumulated depreciation before and after entrance into program ($120,000 + $180,000)		300,000
Unrecovered cost		$ 10,000
Sales price		1,000
Loss		$ 9,000
Share of loss under program = $\frac{15 \text{ yrs (medicare)}}{25 \text{ yrs (useful life)}} \times \$9,000 =$		$ 5,400
Correction of accumulated depreciation under the program:		
Depreciation taken	$185,714	
Correct depreciation	180,000	
Excess depreciation taken		5,714
Reduction of depreciation for the year		$ 314

132.2 Computation of Gain or Loss on Assets Acquired Under the Program.—Gain or loss on the disposal of assets acquired under the program is the difference between the sale price of the asset and the asset's unrecovered cost.

EXAMPLE

Facts:

Asset acquired for	$310,000
Estimated life	30 years
Estimated salvage value	$ 10,000
Asset sold at end of 25th year for	$ 25,000
Sum-of-the-years' digits used in depreciating asset—	
Depreciation for 25 years	$290,325

Computation of Gain or Loss

Sales price of asset		$ 25,000
Less: Unrecovered cost:		
Historical cost	$310,000	
Deduct: Accumulated Depreciation for 25 years	290,325	19,675
Gain on disposal		$ 5,325

Chapter 2

INTEREST EXPENSE

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Chapter 2

INTEREST EXPENSE

200. Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

202. Definitions

202.1 Interest

Interest is the *cost incurred for the use of borrowed funds*, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for one year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. *Interest may be included in "finance charges" imposed by some lending institutions* or it may be a prepaid cost or "discount" in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service charges together with interest on indebtedness are includable in allowable cost.

To be allowable under the Medicare program, interest must be: (1) supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required; (2) identifiable in the provider's accounting records; (3) related to the reporting period in which the costs are incurred; and (4) necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

To support the existence of a loan, the provider should have available a signed copy of the loan contract which should contain the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., will be acceptable.

Where funds are borrowed from the provider's funded depreciation account or other restricted funds, authorization from appropriate officials of the provider should be on file. Appropriate officials of the provider would include the persons to whom responsibility for the management of the restricted amounts or funds has been granted, such as the board of trustees, financial committees, or other individuals or groups, as appropriate in the particular case.

Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement.

Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from the provider premises such as in a county treasurer's office, such records will be deemed to be those of the provider. This would be applicable where bond issues have been specifically designated for the construction or acquisition of the provider's facilities and the financial records relative to the bond issue are maintained by some governmental body other than the provider.

202.2 Necessary

Necessary means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the provider's operations, interest expense is not allowable; such a loan is not considered "necessary." Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost.

Necessary also requires that the interest be reduced by investment income. There is an exception to this general rule where the investment income is from grants and gifts, whether restricted or unrestricted, and which are not commingled with other

funds. "Not commingled" means that the funds are kept physically separate in a separate bank account and not simply recorded separately in the provider's accounting records.

202.3 Proper

Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arms-length transaction in the money market when the loan was made. In addition, the interest must be paid to a lender not related to the provider through common ownership or control. (See Chapter 10, "Cost to Related Organizations" for the definition of common ownership and control.) An exception to the general rule regarding interest on loans from controlled sources of funds is provided in Sections 218.2 and 220.

Where a provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is included in allowable cost, at a rate not to exceed the interest rate the fund is currently earning.

202.4 Prepaid Interest

Prepaid interest is the excess of the face value of a loan over the proceeds of the loan. It is the payment of interest in advance of the period over which the interest expense is incurred.

202.5 Finance Charges

Some lending institutions include in the costs of loans, expenses related to the maintenance of records, collection of delinquent accounts, administration, etc., in addition to the charges for interest. The total of all these costs is known as finance charges, carrying charges, etc. The interest portion of these costs should be so identified in the provider's accounting records since interest must be eliminated in the computation of the "Allowance in Lieu of Specific Recognition of Other Costs." (See Chapter 11.) When service charges are not separated from interest, the entire amount must be eliminated in applying the provisions of Chapter 11.

204. Mortgage Interest

A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other fixed assets.

Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That portion which is for the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable.

In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

206. Interest During Period of Construction

Frequently, providers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be *capitalized* as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction is included in the capitalized cost of the facility constructed.

208. Interest on Loans Covering Multiple Facilities

Where a loan is made to construct, or acquire, a number of buildings (or other fixed assets), the interest on the loan applies to the several assets acquired in proportion to the cost each asset bears to the total cost of the assets. If any building or other asset covered by the loan is not used for purposes related to patient care, the interest applicable to such asset is *not allowable* as a cost of patient care. The proportionate part of such interest applicable to assets used for patient care is an allowable cost.

Examples of fixed assets which might be purchased under a single loan agreement could be land,

buildings, and equipment to be used by the provider in furnishing services to patients, and additional land to be held for future expansion. The land purchased in anticipation of expansion would not be considered related to patient care.

Interest expense for this type of acquisition would be allowable as follows:

Total Amount of Mortgage	$500,000
Land, Buildings, and Equipment Related to Patient Care	$400,000
Land Acquired for Future Expansion	$100,000

In the above situation, 80% ($400,000÷$500,000) of the mortage interest would be includable in allowable costs, while 20% ($100,000÷$500,000) would not be includable in allowable costs.

210. Interest on Notes

A note is contractual evidence given by a borrower to a lender that funds have been borrowed and which states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note. Frequently, a note is issued as an instrument evidencing a loan which may have a term running several years. The interest on such a loan is incurred over the period of the loan. Under the accrual method of accounting, the interest cost incurred in each reporting period is an allowable cost in the applicable reporting period.

If, under the terms of the loan, the interest is deducted when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as cost in the periods over which the loan extends.

212. Interest on Bonds

A bond is an instrument used by both corporations and government entities to borrow funds, usually for long-term capital requirements. A bond is evidence of a liability and bondholders are assured of repayment at some future dates. The terms of the bond are stated in the bond indenture and interest is usually stated as a fixed rate payable in periodic payments such as semi-annually. Interest on bonds is an allowable cost in accordance with the terms of the bond indenture, to the extent that the interest relates to bond proceeds used either to acquire assets for use in patient care activities or to provide funds for operations related to patient care.

212.1 Bond Discount and Expenses

Where bonds are sold at a price below par of face value, the difference between par and selling price represents the amount of discount. Bond discount is, in effect, an adjustment of the interest rate, a premium which the issuing company allows to the purchaser to induce him to buy the bonds at the interest rate stated for the bonds. The discount is considered to be additional interest expense paid in advance and, therefore, is includable in allowable cost. The discount, together with any expense related to the issue, is amortized over the period from the date of sale to the date of maturity of the bonds. Amortization may be made on the straight-line method or by the effective interest method whichever is customarily used by the provider.

Bond expense is the cost of floating a bond issue. Usually, it is made up of legal, accounting, appraisal and engineering fees, registration and printing of the bonds.

212.2 Bond Discount and Expense Treated Separately

Bond discount and expense may be recorded in the same account or in separate accounts. In either event, they are to be treated as described in Section 214.1. However, if they are recorded in one account, and not identifiable separately, the entire amount allowable in each reporting period is considered to be *interest expense* for purposes of Principle 1–11, "Allowance in Lieu of Specific Recognition of Other Costs." In the computation of the allowance in lieu of specific recognition of other costs, interest expense is excluded. If the discount and expense are recorded in separate accounts of the provider or are separately identifiable, the bond discount allowable in the reporting period is *interest* expense; the allowable bond expense is considered as other operating costs.

For example, if a provider issues 5%, 20-year debentures in the amount of $1,000,000, and the bonds are sold at 98 with expenses of issuing of $10,000, the providers accounting records would indicate:

Cash (Dr)	$970,000	
Unamortized Bond Expenses (Dr)	$ 10,000	
Unamortized Bond Discount (Dr)	$ 20,000	
Bonds Payable (Cr)		$1,000,000
Annual Allowable Costs would be:		
Bond Interest (5% of $1,000,000)	$ 50,000	
*Amortized Bond Discount (1/20 of $20,000)	$ 1,000	
Total Interest Costs	$ 51,000	
*Amortized Bond Expenses (1/20 of $10,000)	$ 500	
Total Allowable Costs	$ 51,500	

*If the bond discount and bond expenses were not separately identifiable, for purposes of applying the allowance in lieu of specific recognition of other costs, the total interest cost would be considered as $51,500. If stated separately the total interest cost is $51,000.

214. Bond Premium

Where bonds are sold at a price above face value, the difference between the face value and the selling price represents the amount of bond premium. It is paid by the buyer of the bonds to the selling organization and is actually an adjustment of the total interest expense which is realized when the bonds are sold. The amortized portion of bond premium is a reduction of allowable costs.

214.1 Bond Premium Recorded Separately

Bond premium should be recorded as a deferred credit, and amortized proportionately over the life of the bonds. The portion applicable to each reporting period is a reduction of allowable interest costs for the reporting period. Bond premium should be recorded separately from bond expenses related to the issuance of bonds. Where bond premium and bond expenses are not separately recorded and identifiable, they are in effect netted and the entire amount allocable to the reporting period is considered as bond expenses, and thus interest expense is not reduced for purposes of computing the allowance in lieu of specific recognition of other costs under Principle 1–11.

For example, if a provider issues 5%, 20-year debentures in the amount of $1,000,000 and the bonds are sold at 102 with expenses of issuing of $10,000, the provider's accounting records would indicate:

Cash (Dr)	$1,010,000	
Unamortized Bond Expenses (Dr)	$ 10,000	
Bond Payable (Cr)		$1,000,000
Unamortized Bond Premium (Cr)		$ 20,000
Annual Allowable Costs would be:		
Bond Interest (5% of $1,000,000)	$ 50,000	
*Less Amortized Bond Premium (1/20 of $20,000)	$ 1,000	
Total Interest Costs	$ 49,000	
*Amortized Bond Expenses (1/20 of $10,000)	$ 500	
Total Allowable Costs	$ 49,500	

*In this example, the bond premium and bond expenses are recorded separately and identifiable. If they were not separately identifiable, for purposes of Principle 1–11, the total interest cost would be considered as $50,000. If stated separately the total interest cost is $49,000.

216. Government Bond Issues

Many providers, particularly hospitals, are owned and operated by Federal, State, and local governments. The facilities are constructed or acquired with funds raised by the governmental entity. Governments at all levels, of course, raise funds for operating and capital expenditures by levying taxes and by borrowing through the device of issuing bonds.

216.1 Government Bond Issues for Construction

Some governmental facilities are constructed or

acquired with funds obtained from bond issues *specifically designated* for the construction or acquisition of the facilities. Most of these bond issues are designed to meet the construction costs of more than one facility. In such cases, a proportionate part of the interest payable on the bonds is applicable to the provider and is an allowable cost. If the bond issue is designated for construction of only the provider's facilities, all of the interest expense applicable to the bond issue is allowable.

216.2 General Purpose Government Bond Issues

In some cases, the funds used to construct or acquire the governmental facilities are obtained from the general purpose funds of the government-owner. Even though a portion of such fund is raised through bond issues no part of the interest payable on the bonds is allowable as a cost of the provider.

218. Interest on Loans from Lenders Related to the Provider

One of the elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. (See Chapter 10 for the definition of control and ownership.) Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement for higher rates of interest or for unnecessary loans. This provision is intended to assure that loans are legitimate and needed, and that the interest rate is reasonable. An exception to this general rule is contained in Sections 218.2 and 220.

218.1 Interest Paid to Partners, Stockholders, and Related Organizations

Generally, interest paid by the provider to partners (owners), stockholders, or related organizations of the provider is not allowable as a cost. Where the owner uses his own funds in a business, the funds are considered invested funds or capital, rather than borrowed funds. Therefore, when a partner, stockholder, or related organization makes a loan to a provider, and the interest on the loan is not allowable as a cost, the loan is considered as part of the equity capital of the provider. (See Chapter 12, "Return on Equity Capital," Section 1220.3(e).)

218.2 Interest Paid to Partners, Stockholders, and Related Organizations on Loans Made Prior to July 1, 1966

There is an exception to the general rule stated in Section 218.1. It applies where interest is paid to a partner (owner), stockholder, or related organization on loans made before July 1, 1966, provided that the terms and conditions of payment of such loans have been maintained in effect without modification after June 30, 1966. Interest on such loans made before July 1, 1966, is allowable as a cost.

218.3 Owner(s) of Provider Institution on the Board of Directors of Lending Institution

Owners of providers may sometimes serve as members of the Board of Directors of a bank or other financial institution which lends money to the provider. A determination as to whether a personal relationship or control exists between the provider and lending institution within the meaning of Section 218 will be based on the facts and circumstances of each case.

220. Interest Paid to the Mother House or Other Governing Body of a Religious Order

Providers owned and operated by members of religious orders often obtain funds through loans from the Mother House or Governing Body of the religious order. Where there is a contractual agreement for the payment of interest, and for the eventual repayment of the loan, the interest expense is allowable as cost provided the interest is applicable to the period after the certification of the institution as a provider. Interest expense incurred during a reporting period must be *paid* within the succeeding reporting period.

222. Provider's Unrestricted Funds

Frequently a provider receives gifts and grants to be used for any purpose management determines to be appropriate. These gifts and grants are unrestricted in that the donor has not indicated a particular use to which the donation must be applied. Sometimes, the provider does not use these funds immediately. In such cases, the monies may be "funded," or placed in a physically segregated account, and retained until the provider decides to use them, or they may be recorded in the accounting records designating gifts and grants and the cash deposited with the general funds of the provider.

222.1 Interest Paid to Unrestricted Funds

Where unrestricted funds are used to make "loans" to the general funds of the provider for use in current operations, or for other purposes, interest paid by the general fund to the unrestricted fund is *not allowable* as a cost. Unrestricted funds are available for the use of the provider, and the provider should use them rather than "borrow" them. The same treatment applies to funds created by the provider's restricting its own funds for particular management purposes.

222.2 Interest or Other Income Earned by Unrestricted Funds

Where the provider has invested funds from gifts or grants which are unrestricted as to use, and these funds are commingled with other funds, the provider's allowable interest expense is reduced by the amount of the investment income earned by the fund.

However, if the gifts and grants are not *commingled* with other funds, the investment income earned by the fund does *not* reduce allowable interest expense. "Not commingled" means held physically separate, as deposited in a different bank account from the general funds. The separation of these funds provides identification of both the fund and related income.

222.3 Withdrawals from Unrestricted Funds

An unrestricted fund may contain deposits from gifts and grants and added deposits of general funds reserved for a future use by management. In this case, withdrawals from the fund are considered made from the added deposits of general funds until such funds are exhausted. Income earned by the added deposit of general funds will be applied as a reduction of interest expense.

224. Provider's Restricted Funds

Providers sometimes receive a gift or grant from a donor who specifies that it is to be used for a *specific purpose.* When a provider accepts such restricted funds from a donor, a trustee relationship is established wherein the provider is acting as a trustee for the donor in regard to the funds donated and tht provider is bound by the conditions set forth by the donor. This is a "restricted" gift or grant and must be used for the designated purpose. (See Section 602.) Where the proceeds of a donor-restricted grant or gift are placed in a fund to be retained until it may be used, the fund is known as a restricted fund.

224.1 Interest Paid to Restricted Funds

Where a provider's donor-restricted funds make loans to the general fund of the provider, the interest paid by the general fund to the restricted fund is an allowable cost. Since these funds are not available for use by the provider except as designated, it is expected that the provider would invest them until they are used. For this reason, interest is allowable if the funds are loaned to the general fund.

If these funds are borrowed for construction purposes, the interest earned by the funds would not be applied as a reduction of interest expense; the interest paid to the fund during the period of construction is capitalized as part of the cost of construction and recovered as allowable depreciation.

224.2 Interest or Other Income Earned by Restricted Funds

Where the provider has invested donor-restricted funds and these funds are not commingled with other funds, the investment income from such funds does *not* reduce the allowable interest expense of the provider.

If restricted funds are commingled with the provider's other funds, the investment income earned on the fund does reduce allowable interest expense. In a common fund, restricted funds lose their identity and all earnings are applied as a reduction of allowable interest expense.

224.3 Withdrawals from a Restricted Fund

A donor-restricted fund might contain added deposits made from the general funds of the provider, or from other unrestricted funds. In this case, withdrawals from the fund for other than the specified purposes of the restricted fund are considered to be made first from the added deposits until such deposits are exhausted. These added deposits are considered as *unrestricted funds.* Also, unless the donor specifically provides that earnings applicable to restricted funds may be used for a designated purpose, interest expense must be reduced by such earnings.

226. Funded Depreciation

Funding of depreciation is the practice of setting aside cash, or other liquid assets, in a fund separate from the general funds of the provider to be used for replacement of the assets depreciated, or for other capital purposes. The deposits to the fund are generally in an amount equal to the depreciation expense charged into costs each year, and are in effect made from the cash generated in excess of cash expenses by the non-cash expense depreciation.

Funding of depreciation by a provider may be required under the terms of a bond indenture, mortgage, or other lending agreement, in which the creditors restrict the use of such funds by the providers. In these situations, a trustee relationship is established by contract or agreement, wherein the provider is acting as a trustee in regard to the amounts required to be funded and the use of such funds as stipulated in the agreement.

A provider also may place self-imposed restrictions on the use of funds received equivalent to the depreciation expense for each period and voluntarily fund depreciation. The action to fund depreciation voluntarily would ordinarily be made by the appropriate managing body of the provider, such as the Board of Trustees or Board of Directors, in accordance with the needs and objectives of management. As such needs and objectives change, appropriate action could be taken by the managing body to use all or part of the funds in the funded depreciation account for purposes other than originally intended. Specific provisions of this chapter are applicable to situations where deposits to the funded depreciation account are used for purposes other than originally intended.

Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies.

226.1 Interest Paid on Loans from Funded Depreciation

When the general fund of the provider borrows from the *funded depreciation,* interest paid by the general fund to the funded depreciation account is an allowable cost. The requirements of necessary and proper apply to such loans.

226.2 Interest or Other Income Earned by the Funded Depreciation Account

Where the provider funds depreciation, it is expected that the money in the fund will be invested to earn revenues. Investment income earned by the funded depreciation account is *not* a reduction of allowable interest expense. This provision should be an incentive for the funding of depreciation.

226.3 Deposits in the Funded Depreciation Account

The provider may deposit in this account the cumulative *allowable* depreciation expense, in part or in the entire amount, applicable to its period under the Medicare program. Allowable depreciation is the total amount of depreciation from date of acquisition and is either the total accumulated depreciation recorded in the provider's accounting records or the total accumulated depreciation calculated in accordance with Chapter 1, "Depreciation," Section 114. Further, from time to time, the provider may make "extra" deposits of funds in excess of the accumulated depreciation under the program. Where deposits represent allowable depreciation, or the investment income earned thereon, the provisions of 226.1 and 226.2 apply; where deposits are in excess of the allowable depreciation, the provisions of sections 226.1 and 226.2 do not apply. Any income earned by such extra funds is applied as a reduction of interest expense.

Deposits representing depreciation must be in the funded depreciation account for *6 months or more* to be considered as valid funding transactions and to permit application of sections 226.1 and 226.2. Deposits of less than 6 months duration are not eligible for the benefits of those sections. However, if such deposits representing depreciation are invested at any time before the 6 month period has elapsed, and remain as invested funds beyond the 6 month period, the investment income for the entire period will be treated as provided in 226.2 and will be considered as valid fund transactions.

226.4 Withdrawals from the Funded Depreciation Account

Since deposits in the funded depreciation account may consist of a variety of funds, and to assure that the incentives provided under the program are applied to valid funding transactions, the following sequence of withdrawals will be recognized under the program.

Withdrawals for the acquisition of additional capital assets, including the payment of mortgage principal on these assets, and for investment purposes are made on a first-in, first-out basis. The oldest deposits will be withdrawn first.

Withdrawals for general operating purposes or to make loans to the general funds are made on a last-in, first-out basis. The latest deposit made will be considered the deposit withdrawn for these purposes. For example, if a loan is made to the general fund on February 1, and deposit of the same or greater amount is in the funded account since January 1, the withdrawal will be considered to be made from

the January 1 deposit and interest if any paid by the general fund is *not* allowable as a cost.

Funded depreciation or other deposits in the funded depreciation account may be used by the provider for purposes other than the improvement, replacement, or expansion of facilities or equipment related to patient care. In such cases, allowable interest expense in the period of withdrawal is reduced to adjust for offsets not made in prior years for earnings applicable to such funds. For example, if the provider withdraws funds equal to two years' deposits, using the last-in-first-out method, any earnings applicable to these deposits during the two year period are applied as a reduction of interest expense incurred during the period of withdrawal.

226.5 Money Borrowed to Fund Depreciation

When a provider borrows money to make deposits of funded depreciation, interest paid by the provider on the money borrowed for this purpose is not allowable as cost.

228. Qualified Pension Fund

Generally, a qualified pension plan under Internal Revenue Service regulations is a plan established and maintained by a provider primarily to provide systematically for the payment of definitely determinable benefits to the provider's employees for a period, usually for life, after retirement. The trust instrument establishing the plan would provide for a fund to be accumulated by the trust in accordance with the plan. Deposits of cash or other liquid assets are made to the fund in accordance with the pension plan. In the establishment of such pension funds, a trustee relationship is created with the provider in regard to the deposits into the fund and their use in accordance with the pension plan. The same treatment accorded to deposits of funded depreciation are accorded deposits in the qualified pension fund. (See Sections 226 to 226.5)

230. Interest Expense of Related Organizations

Where a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as a cost, costs of ownership of the leased facility are allowable costs of the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider. (Chapter 10, "Cost to Related Organizations," Section 1008.)

232. Effect of Current Financing Payments

Allowable interest expense on current indebtedness of a provider will be adjusted to accommodate the effect of current financing payments to the provider. This adjustment will reflect the extent to which working capital needs attributable to covered services for beneficiaries have been met by payments to the provider designed to reimburse the provider currently as services are furnished to beneficiaries.

For example, assume the following:

1. Working capital borrowed by Provider	$40,000
2. Current financing payments under Medicare	10,000
3. Total working capital "Borrowed"	$50,000
4. Percentage of allowable cost applicable to Medicare	25%
5. Working capital needed for covered services	$12,500
6. Borrowed funds on which interest would be allowable (line 5 less line 2) ÷ 25%	$10,000

Chapter 3

BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

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Chapter 3

BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

300. PRINCIPLE

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to *specific* deductibles and coinsurance amounts.

302.3 Charity allowances are reductions in *charges* made by the provider of services because of the indigence or medical indigence of the patient.

302.4 Courtesy allowances are reductions in *charges* by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

302.5 Deductible and coinsurance amounts are amounts payable by beneficiaries for *covered services* received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, out-patient diagnostic and therapeutic services, and medical and other health services furnished by a provider of services.

304. BAD DEBTS UNDER MEDICARE

Bad debts resulting from deductibles and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services of individuals covered by the Program will not be borne by individuals not covered, and the costs of services of individuals not covered by the Program will not be borne by the Program. Payment for deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, the inability of the provider to collect deductibles and coinsurance amounts from beneficiaries of the Program could result in part of the costs of covered services being borne by others than beneficiaries of the Program. Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and coinsurance amounts, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all beneficiaries. In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program.

306. BAD DEBTS RELATING TO NON-COVERED SERVICES OR TO NON-BENEFICIARIES

If a beneficiary does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare Program. Likewise, bad debts arising from services to patients who are not beneficiaries of Medicare are not reimbursable under the Program.

Services which are not covered are defined generally in the following Health Insurance Manuals.

HIM–10—Hospital Manual—Section 260

HIM–11—Home Health Agency Manual—Sections 230 and 232
HIM–12—Extended Care Facility Manual—Section 240

308. CRITERIA FOR ALLOWABLE BAD DEBT

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

310. REASONABLE COLLECTION EFFORT

Reasonable collection effort is the amount of effort that should be made to collect a bill, applying sound business judgment under existing circumstances. The amount of effort put forth by providers to collect the deductibles and coinsurance amounts of Medicare patients should be similar to the efforts customarily put forth to collect bills of comparable amounts of non-Medicare patients. Reasonable efforts would include sending collection letters, making telephone contacts, sending telegrams, and/or using a personal approach if this method is customarily used.

These collection efforts should be documented in the appropriate patient's file as support for consideration as a bad debt. The documentation could be in the form of notes on ledger cards, reports of personal contacts, copies of letters and telegrams, or other records.

The provider need not resort to a collection agency unless it customarily does so for its other patients. If a collection agency is used, however, the agency should be advised not to use, or threaten to use, court action unless the uncollectible amount is related to non-covered services. The amounts involved would generally not warrant court action. (See Section 312 for exception to Section 310 procedures.)

310.1 Presumption of Non-Collectibility.—If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. The provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary, and the patient's file should contain documentation of the method by which indigence was determined. If the provider then determines that there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the Section 310 procedures. (See Section 322 for bad debts under State Welfare Programs.)

314. ACCOUNTING PERIOD FOR BAD DEBTS

Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records—ledger cards and source documents—to support his claim for a bad debt for each account included. Further, it would be helpful to the auditors if a listing of beneficiaries and the amounts uncollectible from each one were made to support the amount claimed as allowable bad debts in reporting costs.

316. RECOVERY OF BAD DEBTS

Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the Program is designed to achieve the effect upon reimbursement which would have been achieved had the provider known the amount was collectible.

Where the provider was reimbursed by the Program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such

reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

However, where the provider was not reimbursed by the Program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

318. COLLECTION FEES

Collection fees applicable to all patient accounts are allowable administrative costs. When a collection agency obtains payment of an account receivable, the amount collected is credited to the patient's account and the portion of the amount collected retained by the agency is charged to administrative costs. For example, where an agency collects $40 from the beneficiary, and its fee is 50%, the agency keeps $20 as its fee for the collection service and remits $20 (the balance) to the provider. The provider records the full amount collected from the beneficiary by the agency ($40) in the beneficiary's account receivable and records an amount of $20 in administrative costs. The fee charged by a collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

320. METHODS OF DETERMINING BAD DEBT EXPENSE

320.1 Direct Charge-Off.—Under the direct charge-off method accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. These amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent *deductible* and *coinsurance* amounts applicable to Program beneficiaries and those which are applicable to others than Program beneficiaries or which are for other than covered services. Those bad debts which are applicable to Program beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. (See Sections 300, 302.2, and 316.)

320.2 Reserve Method.—Bad debt expenses computed by use of the reserve method are not allowable bad debts under the Program. However, the specific uncollectible deductibles and coinsurance amounts applicable to beneficiaries and charged against the reserve are includable in the calculation of reimbursable bad debts. (See Section 308.)

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any particular debts, but is based on the aggregate of receivables or services.

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

Under title XIX, State plans under the Federal medical assistance programs are required to pay the Part A deductible and coinsurance for inpatient hospital services through December 31, 1967. The State plan, however, determines to what extent other deductibles and coinsurance amounts under Medicare are paid by the State. Therefore, where a beneficiary eligible under a title XIX plan received covered services prior to 1968, the inpatient hospital deductible and coinsurance unpaid by the beneficiary is not allowable as a bad debt, and the other deductibles and coinsurance amounts not paid by the beneficiary are not allowable as bad debts to the extent the State plan requires the State to pay such amounts.

Effective January 1, 1968, State title XIX plans are required to pay the Part A deductible and coinsurance amounts applicable to inpatient hospital services only for *categorically needy* individuals but not for *medically needy* individuals. Coverage of such deductible and coinsurance amounts for medically needy persons is now optional under a State title XIX plan. This could result in a reduction in State liability for such deductible and coinsurance amounts for title XIX medically needy persons after 1967. As used in this chapter, the terms "categorically needy" and "medically needy" have the same meanings they have under the medical assistance programs. Therefore, unpaid Part A deductibles and coinsurance amounts applicable to inpatient hospital services under Medicare of beneficiaries who are categorically needy welfare recipients are not allowable as bad debts; they must be paid by the States. However, the unpaid deductible and coinsurance amounts of beneficiaries who are medically needy are allowable as bad debts to the extent the State plan imposes cost sharing on the welfare recipients. The portion of care not covered by Medicare must be paid under the public assistance program if the individual would otherwise be eligible for the service.

Where the State is not participating under title XIX, but State or local law requires the welfare agency to pay the deductible and coinsurance amounts, any such amounts unpaid by the beneficiary are not includable in allowable bad debts. Where neither the title XIX plan nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no Program requirement that the State be responsible for these amounts. Therefore, any such amounts uncollectible from the beneficiary are includable in allowable bad debts.

324. PROVIDER-BASED PHYSICIANS—PROFESSIONAL COMPONENT NOT A BAD DEBT

The professional component of a provider-based physician's remuneration is not recognized as an allowable bad debt in the event the provider is unable to collect the charges for the professional services of such physicians. Bad debts are recognized only if they relate to a provider's "allowable" costs. "Allowable" costs pertain only to covered services for which the provider can bill on its *own* behalf under Part A and Part B. They do not pertain to costs of services the provider might bill on behalf of the provider-based physician. Technically, the professional component is a physician charge, not a provider cost. To consider physician reimbursement as a provider cost in determining allowable bad debts would not be in conformance with the law.

326. APPLYING COLLECTIONS FROM BENEFICIARIES

When a beneficiary makes a partial payment of an amount due the provider, the payment is applied in the following order to amounts due:

a. To satisfy the deductible and coinsurance requirements of the hospital insurance program.
b. To satisfy the deductible and coinsurance requirements of the supplementary medical insurance program.
c. To pay the charges for non-covered services.

328. CHARITY ALLOWANCES—COST TREATMENT

Charity allowances are not reimbursable Medicare costs. The charges related to services subject to charity allowances should be recorded at the full amount normally charged to all other patients. The difference between the full charge and the amount to be collected from the charity patient should be appropriately shown in a revenue reduction account. The account reflecting the full charges may then be used to apportion costs in the RCCAC Method of apportionment.

330. COURTESY ALLOWANCES—COST TREATMENT

Courtesy allowances are not reimbursable Medicare costs. The charges for services subject to courtesy allowances should be recorded at the full amount normally charged to all other patients. The difference between the full charge and the amount to be collected from patients entitled to courtesy allowances should be appropriately shown in a revenue reduction account. The account reflecting full charges may then be used to apportion costs in the RCCAC Method of apportionment.

332. ALLOWANCE TO EMPLOYEES

Allowances, or reductions in charges, granted to employees for medical services as fringe benefits related to their employment are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs. However, any costs of the services not recovered by the provider by means of the part of the charge assessed the employee are allowable costs.

332.1 Method for Including Unrecovered Cost.—The unrecovered cost of services furnished to employees as fringe benefits may be included in allowable costs by treating the amount actually charged to the employees as a recovery of costs. Where the cost of the service exceeds the amount charged to the employee, the amount charged to the employee would be applied as a reduction in the costs of the particular department(s) rendering the services. If costs should be apportioned by the RCCAC Method, all charges related to employees' services would be subtracted from the total charges used to apportion such costs, so that unrecovered costs relating to employees' allowances would be apportioned between Medicare patients and other patients. Likewise, where an average cost per diem is used to apportion costs, the days applicable to the employees who received the allowances should

be removed from the total days used to apportion costs.

Where the amount charged to employee exceeds the cost of the services provided, there is no unrecovered cost and, therefore, no cost of fringe benefit. In this case, the amount charged to the employee is not offset against the department costs and the charges for the services given to the employee are not deleted from the total charges. The services furnished to employees are treated the same as services furnished to any other patients.

Example (Where Departmental Costs are Equivalent to 90% of Charges)

	Gross Charges	*Costs*
Other than Employees		
Medicare	$ 900	
Non-Medicare	1,800	
	$2,700	
Employees	300	
Total	$3,000	$2,700
Computation of employee fringe benefit (30% discount):		
To be collected—70% of $300		($210)
Cost applicable to service provided (90% × $300)		270
Unrecovered Cost		$ 60

Total charges	$3,000	Total costs	$2,700
Less: Employee charges	300	Employee payment (Amount charged)	210
Adjusted charges	$2,700	Adjusted cost	$2,490

Payment by Medicare— 900/2700 × $2,490 = $830

The unrecovered cost of $60 remains in the departmental costs and is apportioned among the users of the department other than employees.

Example (Where Departmental Costs are Equivalent to 50% of Charges)

	Gross Charges	*Costs*
Other than Employees		
Medicare	$ 900	
Non-Medicare	1,800	
	$2,700	
Employees	300	
Total	$3,000	$1,500
Computation of employee fringe benefit (30% discount):		
To be collected — 70% of $300		($ 210)
Cost applicable to service provided (50% × $300)		150
Excess of amount charged to employees over cost		$ 60
Unrecovered Cost		None
Payment by Medicare (900/3,000 × $1,500)		$ 450

334. EXAMPLES: COMPUTATION OF BAD DEBTS REIMBURSABLE UNDER THE PROGRAM

334.1 Computation under Part A.—Under Part A, deductibles and coinsurance amounts are subtracted from the HI Program's Share of *allowable costs* in determining the amount reimbursable. Therefore, any uncollectible deductible and coinsurance amounts under Part A represent unrecovered costs to the provider. Bad debts reimbursable under the Program are included in Medicare reimbursement under Part A as follows:

Cost of covered services for HI Program patients		$160,000
Deductible and coinsurance billed to HI Program patients (from provider's records)	$8,500	
Less: Allowable bad debts for deductibles and coinsurance less amount recovered in excess of costs under Part B	1,500	7,000
Balance due provider for covered services		$153,000

(See Section 334.2, Example C, for offset to allowable bad debts.)

334.2 Computation under Part B.—Under Part B, the amount reimbursable by the Program (exclusive of bad debts) is determined by applying 80% to the reasonable cost of covered services furnished to beneficiaries, after application of the deductible provisions. The remaining 20% of the reasonable cost should be recovered from the beneficiary through the coinsurance amount fo 20% of the *charges.* Where the provider's charges exceed costs, coinsurance amounts contain an amount in excess of costs. Where charges

are *lower* than costs, coinsurance amounts are less than the equivalent percentage of costs. Since the Program reimburses the provider for the unrecovered costs resulting from beneficiaries' allowable bad debts, a calculation must be made to determine whether or not there are any such unrecovered provider costs, and whether and to what extent the provider may be reimbursed for bad debts in order to offset any such unrecovered costs.

Where the provider recovers through reimbursement by the Program, together with deductibles and coinsurance amounts collectible from beneficiaries, an amount in excess of the total Part B costs of the Medicare Program, allowable bad debts under Part A are reduced by the amount of this excess.

The cost reports provide a special schedule for making this calculation.

The following examples illustrate the method to be used and the results that could be obtained under the different conditions.

Example A: Provider Charges Higher than Costs—Part B Services

1. Total gross charges all patients	$180,000
2. Total HI Program charges	45,000
3. Percent of HI Program charges	25%
4. Total cost of covered services	$150,000
5. 25% of cost applicable to HI Beneficiaries	$ 37,500
6. Less: Deductibles billed to health insurance patients	2,000
7. Net Cost	$ 35,500
8. 80% of net cost applicable to HI Program	$ 28,400
9. Less: Amount received or receivable from intermediary or SSA	25,560
10. Balance due provider or HI Program	$ 2,840
11. Add: Reimbursable bad debts (line 20 below)	2,500
12. Balance due provider or HI Program (lines 10 plus 11)	$ 5,340

Computation of Reimbursable Bad Debts

13. Total costs applicable to Part B of HI Program	$ 37,500
14. Less: 80% of net costs applicable to HI Program	28,400
15. Balance of costs to be recovered from HI beneficiaries	$ 9,100
16. Deductibles and coinsurance billed to HI Program beneficiaries ($2,000 plus $8,600)	$ 10,600
17. Less: Uncollectible deductibles and coinsurance	4,000
18. Net deductible and coinsurance billed to HI Program patients (if line 18 is equal to or greater than line 15 do not complete lines 19 and 20)	$ 6,600
19. Unrecovered costs from HI Program ($9,100 minus $6,600) (line 15 less line 18)	$ 2,500
20. Reimbursable bad debts (lesser of line 17 or line 19)	$ 2,500

Example B: Provider Charges Lower than Costs—Part B Services

1. Total gross charges all patients	$180,000
2. Total HI Program charges	45,000
3. Percent of HI Program charges	25%
4. Total cost of covered services	$200,000
5. 25% of cost applicable to HI beneficiaries	$ 50,000
6. Less: Deductibles billed to HI patients	$ 2,000
7. Net Cost	$ 48,000
8. 80% of net cost applicable to HI Program	$ 38,400
9. Less: Amount received or receivable from intermediary or SSA	34,560
10. Balance due provider or HI Program	$ 3,840
11. Add: Reimbursable bad debts (line 20 below)	4,000
12. Balance due provider or HI Program (lines 10 plus 11)	$ 7,840

Computation of Reimbursable Bad Debts

13. Total costs applicable to Part B of HI Program	$ 50,000
14. Less: 80% of net costs applicable to Part B of HI Program	38,400
15. Balance of costs to be recovered from HI beneficiaries	$ 11,600
16. Deductibles and coinsurance billed to HI Program ($2,000 plus $8,600)	$ 10,600
17. Less: Uncollectible deductibles and coinsurance	4,000
18. Net deductible and coinsurance billed to HI Program patients (if line 18 is equal to or greater than line 15 do not complete lines 19 and 20)	$ 6,600
19. Unrecovered costs from HI Program ($11,600 minus $6,600) (line 15 less line 18)	$ 5,000
20. Reimbursable bad debts (lesser of line 17 or line 19)	$ 4,000

Example C: Provider Charges Higher than Costs—Part B Services (Collections by Provider Exceed Costs)

1.	Total gross charges all patients	$180,000
2.	Total HI Program charges	45,000
3.	Percent of HI Program charges	25%
4.	Total cost of covered services	$150,000
5.	25% of cost applicable to HI beneficiaries	$ 37,500
6.	Less: Deductibles billed to HI patients	2,000
7.	Net cost	$ 35,500
8.	80% of net cost applicable to HI Program	$ 28,400
9.	Less: Amount received or receivable from intermediary or SSA	25,560
10.	Balance due provider or HI Program	$ 2,840
11.	Add: Reimbursable bad debts (line 20 below)	—0—
12.	Balance due provider or HI Program (lines 10 plus 11)	$ 2,840

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B of HI Program	$ 37,500
14.	Less: 80% of net costs applicable to HI Program	28,400
15.	Balance of costs to be recovered from HI beneficiaries	$ 9,100
16.	Deductibles and coinsurance billed to HI Program beneficiaries ($2,000 plus $8,600)	$ 10,600
17.	Less: Uncollectible deductible and coinsurance	1,000
18.	Net deductible and coinsurance billed to HI Program patients	$ 9,600
19.	Unrecovered costs from HI Program (line 15 less line 18) () indicate collections in excess of costs *	$ (500)
20.	Reimbursable bad debts (lesser of line 17 or line 19)	—0—

* Amount collected in excess of costs is transferred to computation of reimbursable bad debts under Part A and reduces allowable bad debts under Part A. (See Sect. 334.1.)

Chapter 4

COST OF EDUCATIONAL ACTIVITIES

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Chapter 4

COST OF EDUCATIONAL ACTIVITIES

400. PRINCIPLE

An appropriate part of the net cost of approved educational activities is an allowable cost.

402. DEFINITIONS

402.1 Approved Educational Activities—Approved educational activities means formally organized or planned programs of study engaged in by staff members of an institution, as distinguished from "on-the-job", "inservice", or similar work-learning programs. To be an allowable cost, the educational activity must be:

a. Designed to enhance the quality of health care in the institution, or to improve the administration of the institution.

b. Where required, licensed by State law.

c. Where licensing is not required, approved by the recognized professional organization for the particular activity.

The cost of educational and training programs approved by a county or local agency, but which are not licensed by the State, will not be recognized as allowable cost under these criteria.

402.2 Net Cost—The net cost means the direct and general service cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs) less any reimbursements from grants, tuition and donations received for educational purposes.

402.3 Appropriate Part—Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in the principles of reimbursement for providers.

402.4 Approving Bodies—Approving bodies are those organizations and associations which recognize the professional stature of medical and/or paramedical educational programs at the national level. (See Sec. 404 for examples of organizations and associations in this category.)

404. APPROVED PROGRAMS

In addition to approved medical, osteopathic, and dental internship and residency programs, recognized professional and paramedical education and training programs now being conducted by provider institutions, and their approving bodies, include the following:

Program	*Approving bodies*
(1) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic internships	The American Dietetic Association.
(3) Hospital administration residencies.	Members of the Association of University Programs in Hospital Administration.
(4) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records	Council on Medical Education of American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists	The American Association of Nurse Anesthetists.
(8) Professional nursing ...	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational therapy ..	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies ..	American Society of Hospital Pharmacists.
(12) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

404.1 Interns and Residents Not Under an Approved Teaching Program—To be allowable, a medical internship or residency training program must be approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Intern or residency programs in the field of dentistry in a hospital or osteopathic hospital must have the approval of the council on Dental Education of the American Dental Association. There are some institutions which employ interns and residents which do not have any teaching programs for their physicians. In such cases the cost of services furnished medicare patients are reimbursable under Part B. Obviously in this case there are no educational costs.

Other institutions employing interns and residents may have an unapproved program. Here again the costs of services furnished by these interns and residents are covered under Part B, but the costs of this unapproved educational program are not allowable under Part A or Part B. In the latter case, administrative costs related to teaching activities incurred by physicians or others must be reduced by the appropriate amount applicable to these teaching activities. Such adjustments may be made on the basis of time records, if available; schedules established for teaching sessions; or on the provider's estimate of time spent by physicians or others.

404.2 Other Educational Programs—The costs of educational programs not listed above may also be allowable provided they meet the conditions described in this chapter. The provider should refer these to its intermediary for a determination as to whether the costs are allowable.

An example of an educational program for which costs may be allowable includes a program whereby nurses are sent to college to obtain Bachelor of Science degrees in nursing or related health care fields, or other advanced training courses in such subjects on the condition that they work for the hospital for a specific period following completion of the program.

406. PROGRAM PARTICIPATION

Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should pay for increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units. The traditional practice followed in the past with respect to types of services rendered, and the cost related thereto between providers and educational institutions shall be followed. Whether or not a written agreement is executed between the provider and the educational institution, total allowable cost (direct and general service costs—see Chapter 23, Sec. 512) must be reasonable in recognition of services received, or furnished. Such allowable cost must be recorded in the provider's records and be supported by documentary evidence (usually a bill) which identifies the nature and amount of services received or furnished. Joint costs should be equitably distributed between the provider and the related educational institution.

In situations where the provider furnishes a service or provides materials or space to an educational institution, the related costs are allowable only if they are recognized as an educational cost; otherwise, they must be deducted from the appropriate cost center. If the cost for such service, materials, or space cannot be determined, allowable costs shall be reduced by the income due.

408. ORIENTATION AND ON-THE-JOB TRAINING

The costs of "orientation" and "on-the-job training" are not within the scope of this chapter but are recognized as normal operating costs in accordance with the principles set forth in Chapter 21.

410. SUBSIDIES RECEIVED

Some providers which are county, state, or federally owned and operated receive subsidies from these governmental bodies. The subsidies are usually general in nature and are not restricted to payments for a specific element of cost. The provider may, however, spend all or part of the unrestricted subsidy for approved education purposes. Under such circumstances, the appropriate part of education expense may be included in allowable costs and need not be reduced by the funds received from the governmental body.

On the other hand, a provider may receive subsidies that are restricted by the state or local government to further a specific education program of the provider. Funds so received, regardless of their source, shall be treated as reductions of the educational expense of the provider. The principles set forth in Chapter 6 are applicable for subsidies.

412. GRANTS, GIFTS, AND ENDOWMENTS

Funds received for education expense from unrestricted and restricted grants, gifts, and endowments shall be treated in accordance with the principles set forth in Chapter 6.

414. REVENUES RECEIVED

Revenues received through tuition and scholarships will be offset against educational expenses. Reimbursement from provider personnel for meals, uniforms, books or supplies will be offset against educational costs where the costs of these services have been included in educational costs; otherwise, they will be offset against the account to which the expense was charged.

416. OTHER EDUCATIONAL EXPENSES

416.1 Medical Library—The expenses of a medical library including the salaries of librarians, supplies, books, periodicals, etc., are allowable costs.

416.2 Refresher and Post-Graduate Programs—Costs for the planning and conduct of refresher and post-graduate programs related to the improvement of patient care for medical and paramedical personnel of the local area and surrounding communities are allowable. For example, the cost of courses given for the purpose of inducing the return to active services of nurses and technicians who have been out of the field for an extended period would be properly included in allowable costs.

416.3 Part-Time Education—Costs of part-time education for bona fide employees (excluding part-time employees) at properly accredited academic or technical institutions devoted to under-graduate and/or graduate work are allowable costs provided that:

a. Allowable costs are limited to expenses incurred for training materials, text books, and tuition charges by the educational institutions.

b. The employee agrees in writing to complete the course of training and to continue in the provider's employ for a reasonable period, usually not less than 6 months, following completion of the course of study.

When authorizing part-time educational courses for employees, the provider should consider whether:

a. There is a demonstrable need within the provider's organization for the skills, knowledge, and/or attitudes that are expected to result from the employee's participation in the course of training.

b. The course of study undertaken by the employee is the most economical and feasible method of acquiring such skills, knowledge, or attitudes.

c. A direct relationship exists between the recommended training and his job responsibilities.

416.4 Travel Expense—Educational Workshops—Travel expense incurred by a provider to send employees to attend an educational workshop which increases the quality of medical care and/or the operating efficiency of the institution is an allowable cost. Workshops on medical techniques, health applications, data processing, hospital accounting and cost finding, and other administrative activities are some examples of those for which travel expense will be recognized.

416.5 Training in the Use of Medical Appliances—Costs will be allowed if they are incurred for training in the use of medical appliances by the following: (a) the patient, (b) members of the patient's family, (c) other individuals whose responsibility will be to care for the patient after discharge.

Chapter 5

RESEARCH COSTS

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Chapter 5

RESEARCH COSTS

500. PRINCIPLE

Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

502. DEFINITIONS

502.1 Research—Research in the context of this principle means a systematic, intensive study directed toward a fuller scientific knowledge of the science and art of diagnosing, treating, curing, and preventing mental or physical disease, injury, or deformity, relieving pain, and improving or preserving health.

502.2 Usual Patient Care—Usual patient care means those items and services (routine and ancillary) ordinarily furnished in the treatment of patients by providers under the supervision of physicians. Such items or services may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing care, and other related professional health services.

504. DETERMINATION AND ALLOCATION OF COSTS

504.1 Research Conducted Without Patients—Where research is conducted by a provider which does not involve patients, research costs are not includable in allowable costs.

A separate cost center for research should be established in the provider's accounting records and used to record all direct costs such as compensation of employees, materials and purchased services, etc.

Indirect costs such as administration expenses, maintenance, and operational expenses, utility expenses, etc., which are shared by research and usual patient care cost centers should be apportioned to these centers. Where ancillary service departments furnish items or services to research projects, the costs of such items or services including a proportionate share of departmental overhead should be charged to the research cost center.

504.2 Research Conducted With Patients—Where research is conducted in conjunction with and as a part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research. Where research involving patients is fully financed under research grants, usual patient care costs will not be reimbursed under the program, even though patients who are eligible Medicare beneficiaries are participating in the research project.

Where research involving patient care is not financed by research grants, that portion of the cost of research patients attributable to usual patient care is allowable. Extraordinary costs of services and materials associated with the research and not routinely furnished by the provider or furnished where not indicated by the medical condition of the patient are not allowable costs and should be charged to the research cost centers. Such extraordinary costs, for example, might result from the use of highly complex and specialized equipment and facilities, such as electronic computers and reactors; abnormal use of radiology, laboratory, and other departments; and the salaries of personnel with higher professional qualifications than ordinarily needed to furnish usual patient care. Records must be maintained identifying patients in the research project, patient charges, days and such other statistics which may be necessary in the allocation and apportioning of costs.

504.3 Allocation of Research Grants, Gifts, etc., to Usual Patient Care—Where a provider receives gifts, grants, and income from gifts and grants specifically to finance research including usual patient care costs, such funds must be used to reduce total departmental costs which include usual patient care. Where the grant, etc., does not specify how the funds are to be applied, the following method may be used:

Cost Centers	Costs* Applicable to Usual Patient Care (Research Patients)	Percent of Total**	Research Funds	Funds to be Applied as a Reduction of Costs (b)
Laboratory	$ 7,500	2.10	$300,000	$ 6,300
Radiology	12,000	3.36	300,000	10,080
Pharmacy	12,000	3.36	300,000	10,080
Routine Services	40,000	11.18	300,000	33,540
Research (a)	286,000	80.00	300,000	240,000
Total Costs	$357,500	100.00	$300,000	$300,000

* Determined by applying RCCAC, statistics etc. This determination is made after extraordinary costs have been removed from revenue producing cost centers and charged to research expense.

** Ratio of Departmental Usual Patient Care Cost (Research Patients) to Total Usual Patient Care Cost (Research Patients).

(a) Research expenses including extraordinary patient care costs from Worksheet B, Form SSA–1562.

(b) Funds to be applied as a reduction of costs appearing on Schedule B, Form SSA–1562 before transfer to Schedule C of that form.

506. STUDIES RELATED TO ADMINISTRATION AND OPERATION

Studies, analyses, surveys and related activities aimed at improving and making provider administration and operation more efficient are not considered research costs but are includable as allowable administrative costs. See Chapter 21, "Costs Related to Patient Care" for the treatment of such costs.

Chapter 6

GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

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Chapter 6

GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

600. PRINCIPLE

Unrestricted grants, gifts, and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.

602. DEFINITIONS

602.1 Unrestricted Grants, Gifts, and Income from Endowments. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction *by the donor* as to their use.

602.2 Restricted Grants, Gifts, and Income from Endowments. Restricted or designated grants, gifts, and income from endowments are funds, cash or otherwise, which must be used only for a specific purpose designated *by the donor*. This does not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

604. UNRESTRICTED GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS—GENERAL RULE

Unrestricted contributions are not deducted from costs in computing allowable costs. These funds are considered the property of the provider to be used as it deems appropriate. These funds generally give the provider a means of recovering costs which are not otherwise recoverable, such as costs related to bad debts of patients not covered under Medicare.

606. RESTRICTED GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS—GENERAL RULE

Restricted contributions which are designated by the donor for paying certain provider operating costs, or group of costs, or costs of specific groups of patients, are to be deducted from the designated costs or group of costs. Where the cost or group of costs designated covers services rendered to all patients, including Medicare beneficiaries, operating costs applicable to all patients are reduced by the amount of the restricted grants, gifts, or income from endowments and allowable costs are thus reduced. For example, if a specific donation were made to cover the costs of medical social services for all patients, the costs of medical social services would be reduced to arrive at allowable costs. However, the reduction could not exceed the amount of the donation.

606.1 Period in which Funds are Deemed Used.—The *terms of the* contribution are controlling if they specifically state the way in which the funds are to be applied. Otherwise, restricted contributions are deemed to be used in the reporting period in which the gift is received to the extent that applicable costs are incurred after the date of the gift. Generally, the donor of a restricted contribution intends that the provider use the funds for the purpose for which they were given as opportunities occur for such use; therefore, the above order of application is in accord with the purposes of the gift. Restricted contributions not used in the reporting period in which they were received are carried over into the following period, or periods, and used for the designated purpose.

Assume that a provider incurred $10,000 cost for medical social services during a calendar year reporting period. On July 1, he received a contribution of $10,000 which was designated by the donor to be used to provide medical social services for all patients. Examination of the costs of these services indicates that costs of $4,000 were incurred after July 1. Under the principles of reimbursement, allowable costs would be computed as follows:

Total costs of medical social services for the reporting period	$10,000
Portion of such costs incurred after the date of the gift	4,000
Allowable costs of medical social services for the reporting period	$ 6,000

The amount of the restricted contribution would be adjusted as follows:

Contribution as of July 1	$10,000
Costs appropriate to use of funds incurred subsequent to date of gift	4,000
Balance of restricted contribution at end of reporting period	$ 6,000

This balance would be applied to the costs incurred for medical social services during the subsequent reporting period(s).

608. DONATIONS OF PRODUCE OR OTHER SUPPLIES

Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

610. DONATION OF THE USE OF SPACE

A provider may be donated the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use of the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

If the provider and the donor organization are both part of a larger organizational entity, such as units of a State or county government, the costs related to the donated space are includable in the allowable costs of the provider. For example, if a county home health agency is given space to use in the county office building, costs related to that space may be included in the agency's costs. Such related costs would include depreciation, costs of janitorial services, maintenance and repairs.

612. PUBLIC HEALTH SERVICE GRANTS

612.1 PHS Grants—General.—Public Health Service grants are authorized under the Public Health Service Act on a fiscal year basis. In general, the purpose for which the grant was authorized will determine if any of the funds received are applied as a reduction of allowable costs. If for example, the grant were authorized for a provider of health services to be used as the provider deems proper and necessary, the grant would be considered unrestricted and would not be used to reduce allowable costs. However, if the grant were authorized for a provider of health services to pay for certain costs or groups of costs, the grant would be considered restricted and would be deducted from the costs of services for which the grant was made. Further, grants designated to cover only the costs of services provided to patients not covered under Medicare will not be deducted from operating costs in computing allowable costs. If the terms of the grant do not specifically exclude the costs of services to Medicare beneficiaries, such costs are deemed to be covered under the grant and the grant would be deducted from operating costs in computing allowable costs.

The intent of this principle is to avoid duplication of recovery by the provider for costs incurred from the Medicare Program and from other sources, such as Public Health Service grants. An exception to this general rule is provided where "seed grants" are involved. (See Section 612.2 for exception.)

612.2 Seed-Money Grants.—Grants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. Funds received from "seed money" grants are considered unrestricted and would not reduce allowable costs. These grants are usually made to cover specific operating costs or group of costs for services for a stated period of time. During this time, the provider will develop sufficient patient caseloads to enable continued self-sustaining operation with funds received from Medicare reimbursement as well as from funds received from other patients or other third-party payers. "Seed money" grants are not deducted from costs in computing allowable costs.

612.3 Application of General Rules to Grants Under Public Law 89–749.—Under section 314 of Public Law 89–749, Public Health Service Act, grants may be given under five major classifications which are described as:

a. Section 314(a) establishes formula grants to States for comprehensive health planning at the State level through a designated State Agency. These grants are given to the State Health Department to assist the State in "comprehensive and continuing planning for current and future health needs in terms of health services, health manpower and health facilities."
b. Section 314(b) establishes grants for comprehensive health planning at the areawide level "both to support organized programs which conduct and coordinate health and related types of planning activities within regions, metropolitan communities—and to support efforts to organize such programs."
c. Section 314(c) establishes grants for training health planners. Grants are made "to any public

or nonprofit private agency, institution or other organization to cover all or any part of the costs of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the nation."

d. Section 314(d) establishes formula grants to States for public health services. These "block grants" are made to "State Health and mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work." The State in turn may allocate these funds to either public or nonprofit private agencies.

e. Section 314(e) establishes project grants for health services development. These grants are available to cover part of the cost of:
 1. providing services to meet health needs of limited geographic scope or of specialized regional or national significance,
 2. stimulating and supporting for an initial period new programs of health services, or
 3. undertaking studies to develop new methods or improve existing methods of providing health services.

Costs incurred in planning and programming activities for which grants under sections 314(a), (b), and (c) are received which are included in the provider's costs are reduced by the amount of the grants, but not to exceed the incurred costs of the activities.

Grants received under section 314(d) to assist States *to develop new* home health agencies or *to expand the services* of established agencies would be considered "seed money" grants and should not be considered as reductions to the home health agencies' costs in computing reimbursable costs. All other grants received under section 314(d) are considered to be restricted funds for furnishing services to patients. Where the patients designated as covered by these grants include those covered by Medicare, the allowable costs of the agency are reduced by the grants. Where patients covered by Medicare are excluded from the patients designated as covered by the grants, allowable costs are not reduced by the grants.

Regarding grants received under section 314(e), under (1) where the use of the grants is restricted to patients not covered by Medicare, allowable costs are not reduced; however, where Medicare patients are included in the patients designated as covered by these grants, allowable costs are reduced by the amount of the grants. Funds received under (2) will not be used to reduce allowable costs, and funds received under (3) will constitute reductions in allowable costs to the extent that the costs of these activities are included in the provider's allowable costs.

614. COMMUNITY FUND MONIES

Some providers receive financial support through grants or contributions from United Fund or Community Fund monies. Where such contributions are made for the general use of the provider without restriction by the donor, the provider's costs are not reduced by the amount of the contributions. Contributions of funds for operating costs or to reimburse the provider for operating deficits are in this category and would not serve to reduce the provider's allowable costs.

However, where the donor designates a special cost or category of costs, for which the contributions must be used and, in effect, assumes these costs, the designated cost or group of costs is reduced. Such designation could be made, for example, to defray the costs of caring for patients with specified diseases, i.e., cancer.

Chapter 7

VALUE OF SERVICES OF NONPAID WORKERS

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Chapter 7

VALUE OF SERVICES OF NONPAID WORKERS

700. PRINCIPLE

The value of services performed by nonpaid workers who work more than 20 hours per week in full-time positions of kinds that are normally occupied by paid personnel of providers not operated by or related to religious orders is allowable in reimbursable costs as an operating expense. Such amounts must be identifiable in the records of the institutions as a legal obligation. Also, the nonpaid workers must be members of organizations under arrangements with the provider for which such services are rendered without direct remuneration (salaries or wages and gifts) to the nonpaid workers by either organization.

Under this principle, which is effective July 1, 1966, a provider may claim as an allowable cost the value of services of nonpaid workers beginning with the first day of its first cost reporting period *provided* the conditions of this principle and *all* the criteria of Section 704ff are met. A paid Director of Volunteers is includable in the allowable costs of a provider but is not considered under the definition of this principle.

This principle is in accord with the practice of some providers in customarily including a value for the services of certain nonpaid workers in calculating reimbursable costs, e.g., the value of services traditionally provided by Sisters and other members of religious orders under arrangements whereby the provider actually makes payment to the religious order has generally been reimbursed by third parties which pay hospitals on a cost basis.

704. GUIDELINES

704.1 Performance in Positions Customarily Held by Full-Time Employees Performed on a Regular, Scheduled Basis

Nonpaid workers must work more than 20 hours per week in full-time positions of kinds that are normally occupied by paid personnel of providers not operated by or related to religious orders.

704.2 Performance in Positions Necessary for Normal Patient Care and Operation of the Institution

Services must be related directly to patient care or in administrative positions essential to the provision of that care; e.g., nursing, essential office, admitting, switchboard operations, etc. Where the provider would not ordinarily be required to engage others to perform the services of the nonpaid workers in order to properly care for the patient or properly operate the facility, the value of the nonpaid work is not an element of cost.

Services not related to patient care or in administrative positions not essential to the provision of that care, such as distributing books and magazines to patients, or performed in a provider canteen, cafeteria or gift shop, are not reimbursable. Moreover, services rendered gratis by volunteers such as those affiliated with the American National Red Cross, hospital guilds, auxiliaries, and similar organizations are not reimbursable. Such services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered, or by the person rendering the service. In addition, such services are of the type for which payment has not been made by third parties that reimburse providers on the basis of costs.

On the other hand, services necessary for normal patient care and operation of the provider traditionally rendered by Sisters and other members of religious orders under arrangements whereby the provider actually makes payment to the religious order have generally been reimbursed by third parties which pay hospitals on a cost basis and are includable in allowable costs under the Medicare Program.

Whether or not the nonpaid workers are members of a religious order, the arrangements existing between the organization of nonpaid workers and the provider should be considered in deciding whether the services rendered by the nonpaid workers are of a kind that have traditionally been furnished to providers on a purely volunteer basis and traditionally been reimbursable by other third parties. The intent of the Medicare Program is to follow the usual and customary methods of third parties in compensating for such volunteer services.

704.3 Value of Services

The amount recognized in reimbursable costs for

the services of nonpaid workers cannot exceed the amount allowed for paid employees who perform similar services. Where the services of a nonpaid worker are performed in a position unlike any other full-time position in the provider's organization, the amount allowed in reimbursable costs cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services and utilization. The value of similar services necessarily includes actual salaries paid based on regular hours, (excluding overtime hours), and regular rates of pay, plus the costs of maintenance, perquisites, and fringe benefits for paid employees.

(Examples: Maintenance—room and board; Perquisites—free uniforms and laundry; Fringe benefits—vacations, holidays, sick leave and discounts below cost on hospital bills and drugs.) The value of fringe benefits should be based on those fringe benefits furnished a paid employee whose hours of work are comparable to those of a nonpaid worker; where a nonpaid worker's hours are comparable to those of a part-time employee, the value of fringe benefits allowed in establishing the value of the services of the nonpaid worker must be based on the value of fringe benefits to the part-time employee.

704.4 Control by Provider

Nonpaid workers must observe all rules, regulations, and codes of conduct required of regular paid workers by the provider.

704.5 Members of Organizations Having Arrangements with Provider

Nonpaid workers must be members of an organization of nonpaid workers that has arrangements with the provider for the performance of services by nonpaid workers. Membership in the organization must be substantiated by adequate documentation in the files of the organization of nonpaid workers. There must exist a legally enforceable agreement between the provider and the organization of nonpaid workers establishing the obligation to remunerate the organization for services to be rendered. Such agreement must include the following: the amount applicable to the value of services rendered by nonpaid workers, types of services, the title of each full-time position, number of hours, rates of pay (including salary, fringe benefits, perquisites, and maintenance); the period of time during which services are rendered, the time period in which payment for the services may be made (payment may not be made later than the end of the provider's cost reporting period following the reporting period during which the services are rendered); and, the requirement that a provider must maintain proper records as outlined in subsection 704.8. Because the regulation incorporating this principle was issued subsequent to its effective date, the written agreement required by this principle may be made retroactive to cover the first cost reporting period, if *all* other requirements of this principle are met during the cost reporting period although not formalized by a written agreement. Before the imputed value of these services may be allowed, however, there must be a written agreement on file. Where appropriate, providers may submit revised cost statements to include the value of these services.

Also, the amount includable in reimbursable costs cannot exceed the amount required under the terms of the contract for the period during which the contract is in effect; i.e., the amount includable in reimbursable costs will be limited to those services covered during the contract period.

The organization of nonpaid workers must obtain a tax exempt status from the U.S. Internal Revenue Service.

704.6 Direct Remuneration

Reimbursable costs cannot include any imputed value (i.e., any expenses not actually incurred) for the services of a worker who has received any direct remuneration (salaries, wages or gifts) from the provider or from the organization of nonpaid workers. On the other hand, reimbursable costs may include an imputed value for the services of a nonpaid worker who has received from the provider remuneration in the form of perquisites and maintenance. The cost of such forms of remuneration which may be included in allowable costs must be used to reduce the imputed value of the services of nonpaid workers. Where a worker receives direct remuneration from either organization, he cannot be considered a nonpaid worker under this principle.

704.7 Qualifications of Nonpaid Workers

The qualifications of nonpaid workers must be comparable to the qualifications of paid employees performing identical services. Where services of a nonpaid worker are performed in a position unlike any

other full-time position established by the provider, the qualifications must be equivalent to the qualifications for similar services of other providers in the area of similar size, scope of service and utilization.

704.8 Identification in Provider Records

A provider must maintain proper records for the reimbursable services performed by nonpaid workers, identifying established full-time positions and rates of pay in a manner equivalent to the identification in the payroll record for a paid employee of the provider. Also, the provider's files must contain a copy of the agreement between the organization of nonpaid workers and the provider.

The full amount developed, under the terms of the agreement between the organization of nonpaid workers and the provider, for services rendered to the provider by the nonpaid workers, must be entered in the provider's accounts even though only a portion may apply to the Medicare Program.

706. COMPUTATION FOR DETERMINING VALUE OF SERVICES—EXAMPLE

The following example illustrates the computation of the imputed value of the services of a nonpaid worker includable in a provider's reimbursable costs:

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
	NONPAID WORKER				PAID WORKER		
			Fringe benefits, perquisites, and maintenance		Similar services (including salary, fringe benefits, perquisites, and maintenance)		
Name of individual	Position Title	Hours worked	Total Amount	Amount Paid by Organization of nonpaid workers	Total Amount	Total Hours	Imputed Value of Services**
N. Jones	Nurse	2080	$750	$250*	$7,000	2080	$6,500 (a)

(a) $\frac{2{,}080 \text{ (col. 3)}}{2{,}080 \text{ (col. 7)}} \times \$7{,}000 \text{ (col. 6)} = \$7{,}000 - [\$750 \text{ (col. 4)} - \$250 \text{ (col. 5)}] = \$6{,}500 \text{ (col. 8)}$

* Reimbursement made by an organization of nonpaid workers to a provider towards its costs incurred for nonpaid workers; e.g., payment made by a convent of Sisters to a hospital towards its cost in maintaining the convent of Sisters who are members of a religious order and who perform necessary hospital services.

** The portion of the imputed value of services that represents salaries should be included with the cost of "salaries" in the department(s) in which the services of the nonpaid workers were rendered. The remaining portion of the imputed value of services that represents fringe benefits, perquisites, and maintenance should be included with the cost of "other than salaries" in the appropriate department(s) in accordance with the policy of the provider.

Chapter 8

PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSES

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Chapter 8

PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSES

800. PRINCIPLE

Purchase discounts, allowances, and refunds are reductions of the cost of whatever was purchased. Similarly, refunds of previous expense payments are reductions of the related expense.

802. DEFINITIONS

802.1 Purchase Discounts—within the meaning of this principle include cash, trade and quantity discounts (see definitions of these latter terms below). Providers are expected and encouraged to take advantage of available discounts. If a provider's costs are inflated from failure to take advantage of available discounts, when the provider is able to do so, then the intermediary may disallow the excess costs.

802.11 Cash Discounts—are reductions granted for the settlement of debts within a stipulated period before they become due. Thus, the terms "2/10, net 30" on a vendor invoice mean that a 2 percent discount from the purchase price will be allowed if payment is made within 10 days from the date of the invoice.

Example: An invoice for supplies indicates a price of $500 with terms of 2/10, net 30. The provider paying the invoice within ten days would remit $490 in satisfaction of the invoice and this would be the actual cost to the provider.

802.12 Trade Discounts—are reductions from list prices granted to a class of customers before consideration of credit terms.

Example: The invoice for a quantity of supplies purchased indicates a total list price of $2,400 with trade discounts of 30% and 10%, and cash discount terms of 2/10, net 30. The cost to the provider would be $1,481.76 ($2,400 less $720 less $168 and less cash discount of $30.24).

802.13 Quantity Discounts—are reductions from list prices granted because of the size of individual or aggregate purchase transactions.

Example: Paper products are purchased from a supplier during the year and the supplier agrees to grant a 5% discount when the provider's quantity purchases of this type product total at least $1,500. In addition, the supplier allows cash discount terms of 2/10, net 30. For example, having purchased paper products totalling $1,700 the provider would be entitled to a quantity discount of $85 and a cash discount of $32.30; the provider's net cost would be $1,582.70.

802.21 Allowances—are deductions granted or accepted by the creditor for damage, delay, shortage, imperfection or other cause, excluding discounts and refunds.

Example: A provider purchases a quantity of dishes costing $1,200 which is received in a damaged condition. In consideration of the provider's acceptance of the damaged shipment, the supplier grants a $200 allowance to the provider. The supplier also allows cash discount terms of 2/10, net 30. The cost to the provider would be $980 ($1,200 less $200 allowance and $20 cash discount).

802.31 Refunds—are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases. Refunds of container deposits are not purchase refunds under this definition.

802.41 Rebates—represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier, and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

804. ACCOUNTING TREATMENT

Discounts, allowances, and refunds should normally be used to reduce the specific costs to which they apply in the accounting period in which the purchase occurs.

Where the purchase occurs in one accounting period and the related allowance or refund is not received until the subsequent period, where possible, an accrual in the initial period should be made of the amount if it is significant, and cost correspondingly reduced. However, if this cannot be readily accomplished, such amounts may be used to reduce comparable expenses in the period in which they are received.

Rebates in the form of cash payments based on the total value of purchases in one accounting period are not generally received until the subsequent accounting period. Where the amount of the rebate can be determined, it should be accrued in the initial period and costs for that period correspondingly reduced. A reasonable effort should be made to accrue accurate

amounts for allowances and rebates which will be received after the books have been closed. The difference between the accrual and the actual amount received may then be entered in the period in which it is actually received. Where a number of cost centers have received numerous charges from purchases, a rebate in recognition of the total of such purchases should be credited to these cost centers based on an equitable method of allocation.

Rebates which are allowed for services, supplies, medicines, etc., used by a specific group or category of patients, e.g., medicare patients, will be used to reduce allowable costs of such services, etc., for all patients.

806. CONTRIBUTIONS BY VENDORS

Payments to a provider by its vendor will be considered as rebates in determining allowable costs under the program even though these payments may be treated as "contributions" by the provider and the vendor.

Such payments will not be considered rebates, however, when: they are made in response to building or other fund raising campaigns in which community-wide contributions are solicited: or they are in addition to rebates which have been customarily allowed under arrangements between the provider and vendor: or the volume of purchase is so nominal that no relationship to the contribution can be inferred; or the contributor is not engaged in business with the provider or a facility related to the provider. Where any of these conditions are met, the payments will be subject to the provisions of Chapter 6, Grants, Gifts and Income from Endowments.

808. REBATES IN CENTRAL PURCHASING ACTIVITIES

Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds and rebates should be credited to the costs of the provider in accordance with the instructions above. These should not be treated as income of the central purchasing function or used to reduce the administrative costs of that function. Such administrative costs are, however, properly allocable to the facilities serviced by the central purchasing function.

Chapter 9

COMPENSATION OF OWNERS

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Chapter 9

COMPENSATION OF OWNERS

900. PRINCIPLE

A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function (§ 405.426 of Regulation 5 of the Social Security Administration).

901. APPLICATION

The allowance of compensation for services of sole proprietors and partners is the reasonable value of the services rendered. The test of reasonableness applies to the actual compensation of all individuals performing services in connection with the operation of a provider including: (1) employees, officers, and directors owning stock in closely-held corporations; (2) employees, officers, and directors with a substantial ownership or equity in public corporations; and (3) certain employees of trusts (see § 902.6).

902. DEFINITIONS

902.1 **Compensation-Sole Proprietorships and Partnerships.**--The allowance of compensation for services of sole proprietors and partners is the amount determined to be the reasonable value of the services rendered regardless of whether there is any actual distribution of the profits of the business.

902.2 **Compensation-Corporations.**--For purposes of determining whether the total compensation paid to an owner is reasonable, compensation as defined herein means remuneration paid to an owner regardless of the form in which it is paid. (See sections 906 and 906.1.) Compensation may be included in allowable provider cost only to the extent of reasonable remuneration for managerial, administrative, professional and other services related to the operation of the facility.

Payments found to represent a return on equity capital are not compensation and are in no event allowable as an item of reimbursable cost. Nor are such payments considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

902.3 **Reasonableness.**--Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case.

902.4 **Necessary.**--The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

902.5 **Persons Related to Owner.**--Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives:" (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; (6) grandparent and grandchild.

902.6 **Trusts.**--Where a trust operates an institution, or has an interest in the corporation or partnership operating the facility, the compensation of an employee who is the settlor or grantor of the trust, a trustee, or a beneficiary of the trust, is subject to the test of reasonableness.

902.7 **Compensation For Persons Related to Owner.**--The actual compensation to an immediate relative of an owner (as described in § 902.5) is subject to the test of reasonableness. No cost may be imputed for the value of these services.

904. CRITERIA FOR DETERMINING REASONABLE COMPENSATION-GENERAL

In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in the application of the principle, the intermediary (1) establishes ranges of compensation paid to individuals other than owners by comparable institutions in the same geographical area, and (2) applies a set of criteria based on the qualifications and responsibilities of the owner, to determine where he should be placed within the range.

In establishing the ranges, abnormally low amounts of compensation sometimes received by employees of religiously sponsored providers may be ignored since circumstances led to the establishment of their rate of pay which are not applicable to other persons. Although intermediaries are to be guided by the established ranges in evaluating the reasonableness of an owner's compensation, there may be special circumstances where an intermediary, on the basis of its judgment, allows an amount that is outside the established range. This might occur where the provider has certain characteristics or the owner has special qualifications and experience which would make a comparison with other institutions and individuals unrealistic.

904.1 **Factors to be Considered in Determining Comparability of Institutions.**--There are a number of factors involved in the determination of the comparability of institutions which include, but are not necessarily limited to, the following:

1. **The size of an institution.**--The size of institutions can be measured in various ways. The number of beds is an obvious means of measuring the size; however, because of differences in occupancy rates, it may be desirable in some cases to measure size by the number of

patient days for the period in question. The operating budget may also be used as a basis for determining comparability of size. For home health agencies, size will be measured by the number of visits.

2. Classification of institutions.--Institutions should be classified by the type and range of services offered. The type of services has reference to the nature of the services rendered, i.e., medical, surgical, rehabilitative, etc. The range of the services means the extent to which the particular kind of service can be rendered. For example, for rehabilitative services, the range of services refers to the amount and kind of physical therapy available, whether speech therapy is available, etc. In considering the type and range of services rendered, emphasis will be given to those services available in the institution rather than services which are available only when arranged for with other organizations by the provider.

3. Number and types of personnel employed.--This factor refers to the number of personnel employed in the various professional and nonprofessional categories.

4. Geographical location.--In determining the comparability of facilities, geographical location is a consideration. Since consideration is given to the area of the United States in which the institution is located and whether it is in an urban, suburban, or rural setting, differences in prevailing living and wage costs are recognized.

904.2 Factors to be Applied in Evaluating Compensation Within Range for Comparable Institutions.--The factors that are considered in determining the reasonableness of an owner's compensation within the range established for a class of institution include the following:

1. The qualifications of the owner including his educational attainment and experience in similar responsible positions. Education and experience are pertinent only as they relate to the job being performed and the services being rendered. Where an owner-administrator is also a physician, the services evaluated are administrative in nature rather than the actual practice of medicine. Therefore, the compensation allowed is based on the compensation non-physician administrators receive rather than on the rate physicians receive for their professional services.

2. The number and types of professional and other personnel supervised by the owner.

3. The duties and responsibilities of the owner and the actual services rendered.

(a) Information as to the owner's actual duties, responsibilities, hours, and days regularly worked, etc., should be obtained.

(b) The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the manner in which this authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, might perform most day-to-day managerial and supervisory functions in an institution. In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar institutions.

4. Whether the owner performs services for any other institutions or is engaged in any other occupation.

(a) Presumably, where an owner performs services for several institutions he spends less than full-time (i.e., at least 40 hours a week) with each institution. In such cases, allowable compensation shall reflect an amount proportionate to a full time basis.

(b) If an owner is engaged in another activity, such as an owner-administrator also having a private medical practice, he ordinarily could not render full-time services as administrator of the institution.

905 PROCEDURES FOR DETERMINING REASONABLE COMPENSATION

905.1 General.--Intermediaries have the responsibility for evaluating the reasonableness of an owner's compensation in terms of the criteria provided in §§ 904.1 and 904.2. On the basis of information obtained by surveys of providers, intermediaries establish ranges of compensation for comparable institutions. These ranges should be utilized both for final settlement and when setting interim rates.

Where an owner occupies a position other than as administrator, (e.g., nursing supervisor) the determination of the reasonableness of the compensation may be much simpler since there would tend to be more uniformity in the type of service rendered in a position other than as an administrator.

905.2 Surveys.--Surveys shall include all proprietary institutions and a sufficient number of comparable non-proprietary institutions in the same geographical area so that an adequate comparison can be made. The comparison should take into consideration the services and compensation of non-owner administrators of proprietary and non-proprietary facilities.

905.3 Uniform Approach.--The application of this policy requires a consistency in the establishment of ranges of compensation for services in comparable situations. To insure that this consistency is achieved, the Social Security Administration regional offices have the responsibility for coordinating intermediary activities.

There may be situations in which an individual has an ownership interest in providers serviced by different intermediaries. It would be appropriate for intermediaries to inquire of the owner whether such situation does exist and, if so, to coordinate its determination with the other intermediary.

905.4 **New Providers and Future Surveys.**--Where a proprietary provider first enters the program, the owner's compensation is evaluated by its intermediary in terms of the ranges of compensation established for comparable institutions. After a period of time, it may be necessary for intermediaries to resurvey their providers because of changes in compensation levels and changes in the duties and responsibilities of the owners.

905.5 **Few Similar Providers in an Area.**--Where there are a few comparable institutions in an area, it may be difficult for an intermediary to evaluate the reasonableness of an owner's compensation. In such situations, the intermediary may need to obtain information about the ranges of compensation established for comparable institutions in nearby or similar areas. Another method is to use the ranges established for another class of institution and adjust the ranges accordingly. For example, the intermediary, may on the basis of its analysis and judgement, establish as reasonable compensation in a given extended care facility, an appropriate proportion of the compensation paid to administrators of comparably-sized hospitals in the same area. However, where this approach is taken, the fact that hospitals are generally more complex institutions than extended care facilities should be reflected in the determination.

906. **TYPES OF COMPENSATION-CORPORATIONS**

As indicated in § 902.2, compensation for the necessary services of a stockholder-employee or an individual described in § 901 (other than sole proprietors and partners) includes:

1. Salary amounts paid for managerial, administrative, professional, and other services.

2. Amounts paid by the institution for the personal benefit of the owner.

3. The costs of assets and services which the owner receives from the institution.

4. Deferred compensation.

Any payments to an owner in excess of a reasonable level do not constitute compensation or any other allowable cost.

906.1 Other Types of Compensation.--There may be instances in which an owner is receiving compensation in a form that without close scrutiny might not be recognized as compensation. Compensation to an owner includes: (1) supplies and services used for the personal use of the owner, (2) special merchandise ordered from wholesalers for the owner's personal use, (3) wages of a domestic or other employee who works in the home of the owner, (4) personal use of a car owned by business, and (5) personal insurance premium paid for the owner, etc.

Any of the above payments must be included in the owner's total compensation to determine its reasonableness.

906.2 Subchapter S Corporations.--Under Federal income tax law, certain corporations can elect to be treated for tax purposes as a partnership. This election, however, has no effect on reimbursement under the Medicare program, and an owner of a Subchapter S corporation is not considered a partner for purposes of this principle.

906.3 Director's Fees and Consultant's Fees.--All payments by a provider to an owner which are claimed as an allowable cost are included in the owner's total compensation for purposes of determining the reasonableness of the cost claimed. This would include fees received by an owner, regardless of the label placed on them, such as consultant's or director's fees. The determination as to the reasonableness of such compensation is made by comparing it with amounts paid by comparable institutions for comparable services performed by their employees rather than by considering the amounts that outside consultants receive.

907. COMPENSATION-SOLE PROPRIETORSHIPS AND PARTNERSHIPS

A. General.--The allowance of compensation for sole proprietors and partners is the value of the services rendered by the owner. Such an amount may or may not be represented as actual payments which have been made to the owner. There is no direct relationship between the compensation allowance of the owner which is arrived at and the amount of operating profit (or loss) of the facility.

In determining the allowance, the intermediary will be responding to a claim for the value of the services of the owner. That is, the institution will include in its statement of reimbursable cost an allowance for the value of the owner's services and the intermediary will, by applying the criteria contained in this chapter, evaluate the reasonableness of this claim.

B. Actual payments made.--Where a provider has claimed as some other cost (for examples, see § 906.1) an amount paid to a sole proprietor or partner, such amount is combined with the allowance claimed by the provider for the owner's services. This total is then used for determining the reasonableness of the compensation allowance claimed.

C. Other considerations.--Since the compensation allowance for sole proprietors and partners is dependent upon the value of the necessary services rendered, no allowance is granted where such services are not actually rendered. This is true even if an owner is receiving payments from the provider. Therefore, although a partnership agreement might provide for retired partners to continue to receive a share of the partnership profits even though they are not rendering any services, such payments are not considered allowable costs under the program.

907.1 Effect on Return on Equity Capital.--Equity capital of a sole proprietorship or partnership is affected by actual capital withdrawals of the owners. The amount established as the allowance of compensation for the owner's services has an indirect effect on the computation of equity capital in that the recognition of this allowance for reimbursement purposes will influence the operating profit of the provider.

Chapter 10
COST TO RELATED ORGANIZATIONS

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Chapter 10
COST TO RELATED ORGANIZATIONS

1000. Principle

Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

1002. Definitions

1002.1 Related to the provider means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

1002.2 Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

1002.3 Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

1004. Determination of Common Ownership or Control in the Provider Organization and Supplying Organization

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership *or* control are not present in both organizations, the organizations are deemed not to be related to each other.

1004.1 Common Ownership Rule

A determination as to whether an individual (or individuals) possesses significant ownership or equity in the provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or non-profit. In the case of a non-profit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization.

1004.2 Examples of Common Ownership

The following examples illustrate the general application of the common ownership rule and are not intended to prescribe, for use in all cases, fixed percentages for determining when significant ownership or equity in an organization exists. Such a determination must be made on the basis of the facts and circumstances in each case.

Example No. 1

Mr. B owns a 60% interest in the provider organization and a 55% interest in an organization supplying the provider. The provider and the supplying organization are considered related by common ownership since Mr. B possesses significant ownership in both organizations.

Example No. 2

Mr. X owns a 70% interest in the provider organization and a 40% interest in the supplying organization. The remaining 60% interest in the supplying organization is owned in equal amounts by twenty individuals unrelated to Mr. X. Unless the provider can demonstrate to the satisfaction of the intermediary that Mr. X's ownership interest in the supplying organization is not significant, the organizations are considered related to each other by common ownership.

1004.3 Control Rule

The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

The facts and circumstances in each case must be examined to ascertain whether legal or effective control does, in fact, exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

1004.4 Examples of Control

Example No. 1

Dr. A is the medical director of a provider, but he does not have an ownership interest in the provider. He is also the president and owner of a supplier organization that provides various therapeutic services primarily to the provider. Under the circumstances described, it will be presumed that Dr. A has the power to influence or direct both the provider and the supplying organization, and that the organizations are related to each other by common control.

Example No. 2

Mr. A owns a 60% interest in the provider organization. Mr. A's two sons and wife together own a 100% interest in the organization supplying the provider. Under the circumstances described, it will be presumed that Mr. A has the power to influence and direct the actions of his family relating to the operation of the supplying organization, and that the organizations are related by common control.

Example No. 3

A construction company builds a facility and leases it to an operating company which becomes a provider. Mr. A owns a 100% interest in the construction company and a 35% interest in the operating company. Mr. B, a key employee of the construction company, owns a 20% interest in the operating company. Under the circumstances described, it will be presumed that Mr. A, as the employer of Mr. B in the construction company, can influence Mr. B's decisions relative to the operation of the provider and that the construction company and the provider are related by common control. (Mr. B would probably not jeopardize his position in the construction company by opposing Mr. A's wishes in the management of the provider.)

Example No. 4

Mr. H owns a 45% interest in Corporation X, the provider organization. The remaining 55% interest is owned by Corporation Y, the supplying organization. Mr. H owns a 100% interest in Corporation Y. Mr. H controls 100% of Corporation X, his own 45% direct interest in Corporation X and the indirect 55% interest owned by Corporation Y. Mr. H has complete control over both the provider and supplying organization; therefore, the organizations are related by control.

1006. Rental Expense Paid to a Related Organization

A provider may lease a facility from a related organization within the meaning of the principles of reimbursement. In such case, the rent paid to the lessor by the provider is not allowable as cost. The provider, however, would include in its costs the costs of ownership of the facility. Generally, these would be costs such as depreciation, interest on the mortgage, real estate taxes and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider. (See section 1212. of Chapter 12, regarding the treatment of the owner's equity in the leased assets.)

1008. Purchase of Facilities from Related Organizations

Where a facility is purchased from an organization related to the purchaser by common ownership or control, the seller's cost of the facility shall be used by the purchaser as the historical cost of the facility. Any accumulated depreciation applicable to the facility must also be recognized by the purchasing organization in recording the purchase of the facility for Medicare purposes. The exception provided under section 1010. of this chapter is not applicable since the sale of such facilities would not meet the requirement that there be an open, competitive market for the facilities furnished.

Example

A construction company builds a facility for an operating company which becomes a provider. Mr. X owns a 100% interest in both organizations. The provider organization and the construction company are considered related; therefore, the construction company's costs of building the facility must be used by the provider as the historical cost of the facility.

1010. Exception to the Related Organization Principle

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary:

a. That the supplying organization is a bona fide separate organization;

b. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

c. That the services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

d. That the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

1010.1 Example of Exception

The exception was intended to cover situations where goods and services are supplied to the general public and only incidentally are furnished to related organizations.

For example, a druggist owns a drug store and has a substantial interest in an extended care facility. The drug store operates as an independent business, serving both the general public and the extended care facility. A substantial amount of the business of the drug store is done with the general public. Therefore, the exception to the principle applies and the amounts *charged* to the provider by the drug store are allowable as costs, not to exceed the amounts charged to the general public or to other institutions for similar services.

1012. Rental of Hospitals or Extended Care Facilities

The exception provided under section 1010. is not applicable to rentals of hospital facilities and nursing homes or extended care facilities. Rental of such facilities would not meet the requirement that there be an open, competitive market for the facilities furnished. The exception contemplates quantities of goods or services made available to the general public, part of which would be the provider.

Chapter 11

ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

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Chapter 11

ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

1100. PRINCIPLE

An allowance in lieu of specific recognition of other costs in providing and improving services is includable as an element of the reasonable cost of services of providers.

1102. GENERAL

The allowance in lieu of specific recognition of other costs is an amount of costs included with costs otherwise allowable for reimbursement under medicare to make up total allowable costs. Difficulty in measurement, lack of adequate data, and other considerations have precluded specific recognition of various elements which are germane to costs of services for beneficiaries. Also, there is some lack of precision in the methods for determining costs at the present stage of development of cost finding which represents a contingency for which recognition is appropriate. The allowance under this principle represents elements of costs otherwise not specifically recognized and is appropriately included in the costs of services provided.

1104. RATE OF ALLOWANCE

The allowance in lieu of specific recognition of other costs is determined by applying a percentage rate to a base amount of costs (See Section 1106) determined to be allowable under the principles of reimbursement. The following rates are applicable in determining the amount of the allowances:

Non-profit providers	2%
Proprietary providers	1½%

The reduction in the allowance rate for proprietary providers is made because a return on equity capital is specifically recognized as a cost for proprietary providers. (Reg. Sec. 405.429).

1106. COST BASIS FOR COMPUTING ALLOWANCE

The base amount of costs to which the rate is applied in determining the allowance under this principle is allowable costs, as determined under the principles of reimbusement, excluding:

a. interest expense (see Chapter 2)

b. the allowance under this principle, and

c. for proprietary providers, the return allowed on equity capital (see Chapter 12)

Chapter 12

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

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Chapter 12

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

1200. Principle

An allowance of a reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period, or portion thereof covered under the program.

1202. Definitions

1202.1 Equity Capital

Equity capital means (1) the provider's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds), and (2) net working capital maintained for necessary and proper operation of patient care activities (excluding the amount of any current payment made pursuant to Chapter 24 of this manual). In effect, equity capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicare program), adjusted for those assets and liabilities which are not related to the provision of patient care.

1202.2 Plant, Property, and Equipment

The classification "plant, property, and equipment" includes all assets and liabilities not specifically classified otherwise in the definition of equity capital in Section 1202.1. Primarily, this would include fixed assets and and long-term debt, but in view of the variety of balance sheet presentations of assets and liabilities, "plant, property, and equipment" must be defined in the more inclusive manner, i.e., buildings, land, fixtures and equipment, goodwill, and other assets not part of current assets. Also, included in this category is any long-term debt not specifically related to particular items of plant, property, and equipment.

1202.3 Net Working Capital

Working capital is the difference between current assets and current liabilities. For provider reimbursement purposes, net working capital is working capital reduced by any amount determined to be excessive for the necessary and proper operation of patient care activities. (Unless specifically stated otherwise in the manual, current assets and current liabilities are determined in accordance with generally accepted accounting principles.)

1202.4 Proprietary Providers

The term "proprietary providers" means providers, whether sole proprietorships, partnerships, or corporations organized and operated with the expectation of earning profit for the owners, as distinguished from providers organized and operated on a nonprofit basis.

1204. Base for Computing Return

The base amount of equity capital to be used for computing the allowable return is the *average* investment of the owners during the reporting period. Investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other cost purposes under the health insurance program. The equity capital in each month is determined and an average of the monthly amounts computed. This is the average equity capital in use during the period. Where the period is less than a year, a proportionate amount of the return is allowable, i.e., seven month period—only 7/12ths of the return is allowable.

1206. Rate of Return

The rate of return on average equity capital is a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program. The rate of return varies as the interest rates on such issues of public debt obligations vary.

The percentage rate is determined by the Social Security Administration and communicated through the intermediaries.

1208. Deposits on Leases

Funds deposited by a provider who leases plant, property, or equipment used for patient care are includable in equity capital if the deposits are required by the terms of the lease. The deposits must be reduced by any noncurrent liabilities related to such deposited funds. Any additional deposits or reductions in deposits required under the lease are treated as additional investments or withdrawals of capital when the transactions occur.

1210. Loans from Owners

Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable as costs are not subtracted from assets in computing the owners' equity capital. Funds obtained through such loans are considered as invested capital of the provider. (See Chapter 2, Section 218 of this manual.) By not subtracting them from assets. the equity capital of the owners is increased.

The following debts representing loans from owners or related organizations are not subtracted from assets in computing equity capital:

1. Loans from owners or related organizations made after June 30, 1966.

2. Loans from owners or related organizations made before July 1, 1966, where the terms and conditions of payment *have been modified* after July 1, 1966.

3. Non-interest bearing loans, regardless of when the loan was made.

Debts representing loans from owners or related organizations made before July 1, 1966, are subtracted from assets where the terms and conditions of payment have *not* been modified subsequent to July 1, 1966.

Transferable debenture bonds issued to owners as evidence of loans are treated as though they were issued to non-owners and are subtracted in determining the provider's equity capital. However, nontransferable debenture bonds issued to the owners are treated as loans from owners in accordance with Chapter 2 of this manual.

1212. Assets Leased from Related Organizations

Generally, reimbursement to any provider leasing facilities or equipment from a "related organization" is limited to the costs of ownership of the leased facilities (depreciation, taxes, interest expenses, etc.) in accordance with Chapter 10 of this manual, just as though the provider owned the facilities. Therefore, the owners' equity in the leased assets is includable in the equity capital of a proprietary provider. (See Chapter 10, Section 1010 of this manual for an exception to this general rule.)

1214. Goodwill

Goodwill purchased in the acquisition of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles.

However, goodwill which has not been purchased but has been internally generated as, for example, from a reorganization of the provider, is not includable in the provider's equity capital.

1216. Gifts and Grants

Gifts and grants which are unrestricted as to use are includable in the provider's equity capital. (See Chapter 12, Section 1220.2g.) However, restricted gifts and grants are *not* includable in the provider's equity capital.

1218. Exclusions from Equity Capital

1218.1 Exclusions—General Rule

Assets and liabilities not related to providing patient care are not includable in the provider's equity capital. Excludable assets and liabilities not specifically treated elsewhere in this chapter are discussed in this section.

1218.2 Invested Funds

Invested funds are funds diverted to income producing activities which are not related to patient care. Any portion of the provider's general funds or operating funds invested in such activities for more than six consecutive months is not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds." Further, if the time period covered by such fund investment is interrupted by a number of withdrawals and redeposits so that the effect of such transactions is that funds are invested for more than six consecutive months, these invested funds are not included in equity capital.

1218.3 Funded Depreciation Account

Where the provider establishes an account in which amounts representing payments received, or amounts accrued, for depreciation expense are deposited, the amounts deposited in this account and the

earnings on the funded depreciation which remain in the fund are not includable in equity capital.

1218.4 Assets Held in Anticipation of Expansion

Land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets will also be excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.

1218.5 Cash Surrender Value of Life Insurance

Where a provider carries life insurance on officers and key employees, with the provider designated as the beneficiary, the cash surrender value of the policy should be shown as an asset. Any cash surrender value of such insurance is not included in equity capital.

1220. Calculation of Average Equity Capital

1220.1 General

The average equity capital of the provider is determined by adding to the balance of equity capital at the beginning of the reporting period, the month by month net changes resulting from certain specific transactions as indicated in the following sections. All elements entering into the net difference between the equity capital at the beginning of the period and the equity capital at the end of the period are accounted for in the computation. An average amount of the monthly balances in use during the period is then computed. By this method the provider is not required to maintain his records on a full accrual accounting basis at any time except at the end of the reporting year.

1220.2 Deficits or Accumulated Losses

As a result of losses in the operation of a facility, sometimes over a number of cost reporting periods, the investment of the owners may be decreased to an amount less than the original investment or may even be eliminated. These accumulated losses are usually shown as a deficit in the Retained Earnings account or other capital account of a corporation and, where proprietorships and partnerships are concerned, are reflected in the balances in the owners' capital accounts.

Such accumulated losses are reflected on the determination of equity capital as reductions of the owners' original investment. Since equity capital is, in effect, the net assets of the owners used during the period to provide patient care, where net assets are reduced for whatever reason, the owners' equity is reduced. Where a negative amount is shown in the owners' equity there, of course, is no basis for allowing a return on equity capital.

1220.3 Factors in Calculation of Average Equity Capital

a. *Equity capital at the beginning of the period*—This amount is the owners' equity in the provider's assets and liabilities related to patient care at the beginning of the cost reporting period, based on the assets and liabilities of the provider as stated under the principles of reimbursement of Medicare.

b. *Capital investments during the period*—This includes additional amounts of new capital invested by the owners in the patient care activities of the provider. Capital investments are included in the computation in the month in which they are invested. Transfers of stock between owners do not affect the capital invested.

c. *Gain or loss on sale of assets*—This includes the gain or loss on the sale of assets as determined under the provisions of Chapter 1 of this manual. Such gains or losses are included in the calculation in the month in which they are realized. Gross receipts from the sale of any asset not related to patient care (excluded from equity capital) are included in this category if they are put into the general operating funds.

d. *Withdrawals by owners*—Equity capital is reduced by withdrawals of cash or other assets by the owners. These withdrawals may be in the form of reductions of invested capital, dividend distributions, payments of personal expenses of owners from the operating funds or other funds related to patient care, or drawings of owner's salary or living expenses not reflected in the profit or loss account. Such withdrawals are included in the calculation in the month in which they are made.

e. *Loans from owners*—Loans from owners which are considered as invested capital under the provisions of Section 1210 are included in this category. Loans made are included in the calculation in the month in which they are made and repayments of loans are included in the month in which they are repaid in the "Other Increases" column.

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f. *Changes due to operations*—Equity capital increases or decreases during the reporting period when net income is earned or when net losses are incurred in operations of the provider. These net increases or decreases may result from patient care activities, including Medicare, or from activities not related to patient care which increase or decrease net patient care assets. One of these changes is the *net profit or loss* from patient care activities. Another such change results when revenue from nonpatient care activities is commingled with the operating fund and used in activities related to patient care.

The net amount of the change in equity capital from this category of transactions is determined by analyzing the difference between equity capital at the beginning of the period and the equity capital at the end of the period. From this net increase or decrease in equity capital are subtracted the amounts included under the other categories of changes on the worksheet for the computation of the return on equity capital. The remainder then will represent the increase or decrease due to operations; however, any amount for a return on equity included in the difference between the beginning and ending equity capital is excluded from this remainder. In the computation, the increase or decrease due to operations is considered as occurring uniformly during each of the months of the reporting period.

g. *Other increases*—Equity capital may be increased by gifts or grants which are unrestricted as to use. Such increases are included in the calculation in the "Other Increases" column in the month in which the gifts or grants are received. Where such gifts or grants consist of small amounts they may be included in the amount determined as the "change from operations."

h. *Equity capital at the end of the month*—Where the equity capital at the end of a month after all increases and decreases in that month have been taken into consideration is a negative amount, show a zero in column 8. The purpose of this principle is to give the owners credit for all their capital invested and used in patient care. If a negative amount is used in column 8, instead of a zero, the owner would be penalized for not having equity capital. Therefore, a zero should be inserted and used in the computation of the average.

1220.4 Examples

Following are two examples with explanatory notes of additions and subtractions which will be considered in calculating average equity capital.

Notes for Case Studies

An examination of the provider's accounting records discloses the following:

Column No. 2—Equity capital at the beginning of the period, based on the provider's balance sheet under Medicare regulations.

Case No. 1—$10,000

Case No. 2—($10,000)

(Negative Equity Capital)

All other elements are considered to be identical for both case studies.

Column No. 3—Additional investments of $5,000 each were made in July and October.

Column No. 4—A loss of $4,000 was incurred in March as a result of the sale of an asset and a gain of $6,000 was realized in August as the result of the sale of another asset.

Column No. 5—Withdrawals of $800 per month for salaries were made by the owners. These withdrawals were recorded in the owners' drawing accounts and are not included in the profit or loss computation. If these amounts withdrawn by owners as salaries were included in the computation of profit, they would not be entered here.

Column No. 6—A loan of $5,000 was made to the provider by an owner in February 1967, and repaid in July.

Column No. 7—Operating profit and other changes due to operations for the period amounted to $24,000; this does not include any amounts withdrawn by the owners as salaries. It also includes amounts representing revenues from the gift shop operated by the provider.

Column No. 8—When the elements of equity capital in each month result in a negative amount, or deficit, when combined into a total figure in column 8, a zero (0) is entered in this column and used in the average computation.

Computation of the amount of return is based on an assumed rate of 7%. This rate is used only for illustrative purposes, and is not intended to be the rate which the provider will use. The actual rate is furnished by the intermediary.

The amount of reimbursable return will be determined based on the ratio of total reimbursable costs to total allowable costs. For example, if total allowable costs are $100,000, all allocable to Medicare patients, 100% of the computed return is reimbursed. If $60,000 of the $100,000 is allocable to the program, 60% of the return is reimbursed. Where the reporting period is less than a full year, a proportionate amount of the return is allowable.

EXAMPLE NO. 1

COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Month	Equity Capital Beginning of Period	Capital Investments during Period	Gain or (loss) Sale of Assets	Withdrawals or Dividend Distribution	Other Increases or (Decreases)	Increases or Decreases Due to Operations	Equity Capital End of Month (Net total of Col. 2 thru 7)
1	2	3	4	5	6	7	8
1. January	$10,000	$ –0–	$ –0–	$(800)	$ –0–	$ 2,000	$ 11,200
2. February	10,000	–0–	–0–	(1,600)	5,000	4,000	17,400
3. March	10,000	–0–	(4,000)	(2,400)	5,000	6,000	14,600
4. April	10,000	–0–	(4,000)	(3,200)	5,000	8,000	15,800
5. May	10,000	–0–	(4,000)	(4,000)	5,000	10,000	17,000
6. June	10,000	–0–	(4,000)	(4,800)	5,000	12,000	18,200
7. July	10,000	5,000	(4,000)	(5,600)	–0–	14,000	19,400
8. August	10,000	5,000	2,000	(6,400)	–0–	16,000	26,600
9. September	10,000	5,000	2,000	(7,200)	–0–	18,000	27,800
10. October	10,000	10,000	2,000	(8,000)	–0–	20,000	34,000
11. November	10,000	10,000	2,000	(8,800)	–0–	22,000	35,200
12. December	10,000	10,000	2,000	(9,600)	–0–	24,000	36,400 (a)
13. Total							$273,600

(a) The provider's year-end balance sheet, under medicare regulations, must reflect this amount as owner's equity.

14. Total Dollars (from Col. 8, Line 13)		Number of Months in Reporting Period		Average Equity Capital During the Period		Rate of Return		Amount of Return for Twelve Month Period
$273,600	÷	12	=	$22,800	×	7.000%	=	$1,596

15. Amount allowable for current period (1/12 of line 14 for each month in the current reporting period) $ *

*Do not use line 15 if reporting period is full year.

EXAMPLE NO. 2
COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Month	Equity Capital Beginning of Period	Capital Investments during Period	Gain or (loss) Sale of Assets	Withdrawals or Dividend Distribution	Other Increases or (Decreases)	Increases or (Decreases) Due to Operations	Equity Capital End of Month (Net total of Col. 2 thru 7
1	2	3	4	5	6	7	8
1. January	$(10,000)*	$ –0–	$ –0–	$(800)	$ –0–	$ 2,000	$ –0–
2. February	(10,000)	–0–	–0–	(1,600)	5,000	4,000	–0–
3. March	(10,000)	–0–	(4,000)	(2,400)	5,000	6,000	–0–
4. April	(10,000)	–0–	(4,000)	(3,200)	5,000	8,000	–0–
5. May	(10,000)	–0–	(4,000)	(4,000)	5,000	10,000	–0–
6. June	(10,000)	–0–	(4,000)	(4,800)	5,000	12,000	–0–
7. July	(10,000)	5,000	(4,000)	(5,600)	–0–	14,000	–0–
8. August	(10,000)	5,000	2,000	(6,400)	–0–	16,000	6,600
9. September	(10,000)	5,000	2,000	(7,200)	–0–	18,000	7,800
10. October	(10,000)	10,000	2,000	(8,000)	–0–	20,000	14,000
11. November	(10,000)	10,000	2,000	(8,800)	–0–	22,000	15,200
12. December	(10,000)	10,000	2,000	(9,600)	–0–	24,000	16,400 (a)
13. Total							$60,000

*Indicates Negative Equity Capital. (a) See example No. 1, Note (a)

14. Total Dollars (From Col. 8, line 13)		Number of Months Reporting Period		Average Equity Capital During the Period		Rate of Return		Amount of Return for Twelve Month Period
$60,000	÷	12	=	$5,000	×	7.000%	=	$350

15. Amount allowable for current period (1/2 of line 14 for each month in the current reporting period $ *

*Do not use line 15 if reporting period is full year.

Chapter 21

COSTS RELATED TO PATIENT CARE

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Chapter 21

COSTS RELATED TO PATIENT CARE

2100. PRINCIPLE

All payments to providers of services must be based on the "reasonable cost" of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.—Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and level of occupancy. It is the intent of the program that providers will be reimbursed the actual costs of providing high quality care, however widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization and other relevant factors.

2102.2 Costs Related to Patient Care.—These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs not Related to Patient Care.—Costs not related to patient care are costs which are *not* appropriate or necessary and proper in developing and maintaining the operation of *patient care* facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to visitors or employees; costs of drugs sold to other than patients; cost of operation of a gift shop; and similar items.

2104. UNALLOWABLE COSTS RELATED TO PATIENT CARE

2104.1 Ambulance Service.—Ambulance service is covered under the supplementary medical insurance plan—Part B. Where a provider furnishes ambulance service to program beneficiaries, reimbursement is made under Part B, based on the reasonable *cost* of such services. Therefore, the costs of ambulance services must be removed from the provider's costs under Part A.

2104.2 Private Room Not Medically Necessary.—Where a patient occupies a private room in an institution which offers semi-private accommodations, and the private room is not considered medically necessary, the Medicare program will pay only the costs of the most prevalent semi-private room. The difference between the private room charge and semi-private room charge may be billed to the patient, provided the patient requested the private room with the knowledge that he would be charged the differential.

2104.3 Private Duty Personnel.—The costs of private-duty nurses and other private-duty attendants are not included in allowable costs. Services of private nurses and attendants are specifically excluded from coverage by law.

2106. COST OF TELEPHONE AND TELEVISION SERVICES

2106.1 General.—The costs of telephone and television services used exclusively for the convenience or entertainment of the patients are not includable in allowable costs of providers (both hospitals and ECF's) under the Medicare program. However, the cost of a nurse-patient communication system that has no capability for other than communications between patient and nurse (or other facility employees) are includable in allowable costs. Similarly, costs of

closed circuit television monitoring systems used by providers for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the provider's operations and have no capability beyond these stated purposes are includable in allowable costs.

2106.2 Combination Purpose Systems.—Some nurse-patient communication systems based on closed circuit television are used in part for bringing in outside entertainment. Likewise, some patient communication systems operate through the telephone line and such a system may also be used, in part, by the patient for making or receiving outside calls.

Where providers use the combined systems, the basic cost of the components designed and used for patient care communication will be an allowable cost. Any incremental costs attributable to the additional components or capability for providing for the patient's entertainment or convenience are not allowable and must be excluded. Where this distinction cannot be clearly made, particularly as it applies to maintenance, the intermediary may approve an allocation covering these incremental costs (usually nominal) based on an equitable sharing.

Occasionally, nurse call systems which do not provide closed circuit television for patient care services are tied by some adjunct linkage into the audio component of a television set. In such instances, the cost of set and maintenance of the equipment providing the television capability is not an allowable cost, except to the extent the provider can demonstrate and the intermediary approves an equitable share (usually nominal) attributable directly to costs arising out of the adjunct linkage and use of the set for nurse call.

2106.3 Costs Incurred in Reliance on Intermediary Letter No. 91 dated July 20, 1966.—Some providers may have contracted for installing telephone and television systems on and after July 20, 1966, in reliance on guidelines published by the Social Security Administration in Intermediary Letter No. 91 and interpretations obtained from intermediaries that the items contracted for were an integral part of the nurse-patient communication system. Other providers may have proceeded on the basis of Intermediary Letter No. 91 and assurances from reputable manufacturers that the systems installed on and after July 20, 1966, were truly integrated systems. Some providers may have had systems in operation or contracted for the installations before July 20, 1966, and continued the systems without change in reliance on either of the foregoing reasons.

Where such a provider documents that his reasons for installing or continuing in operation what could reasonably have been considered to be an integrated system were based on reliance on Intermediary Letter No. 91, the intermediary will determine whether to apply the following temporary savings clause. If the intermediary agrees with the provider, the intermediary will authorize inclusion in allowable costs of appropriate costs of the system it would have allowed under Intermediary Letter No. 91 starting on July 1, 1966 (or the installation date, if later) and ending on June 30, 1967. On and after July 1, 1967, the allowable expenses for television and telephone in these provider institutions must meet the criteria in sections 2106.1 and 2106.2.

2108. COSTS OF PROVIDER-BASED PHYSICIANS

The cost of physician services which are not directly related to medical and surgical service provided to individual patients is an allowable cost of the provider. These services include, for example, teaching, administration, supervision of professional or technical personnel, and laboratory quality control activities. Reimbursement for the reasonable cost of such services will be made under Part A where they relate to inpatient services and where they relate to outpatient hospital diagnostic services provided through March 31, 1968. Reimbursement will be made on a reasonable cost basis under Part B for such services where they relate to (1) outpatient services provided before April 1, 1968, which are not diagnostic services, (2) all outpatient hospital services provided after March 31, 1968, or (3) where Part A coverage has been exhausted in the case of inpatient ancillary services.

However, the costs of physician services which are related to identifiable medical services to individual patients are reimbursable under Part B on a reasonable charge basis. These are services which contribute to the diagnosis of the condition of the patient or contribute to the treatment of such a patient. HIR–4, Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians, discusses this subject in detail.

The costs of the medical and surgical services furnished by the physician which are to be excluded from the provider's allowable costs include the applicable portion of the physician's salary and related fringe benefits such as payroll taxes, vacation pay, meals, and other similar benefits furnished by the provider at no cost to the physician.

Ordinarily, the compensation paid to the physician is for all of the services he performs, in proportion

2108. REIMBURSEMENT FOR SERVICES BY PROVIDER-BASED PHYSICIANS

2108.1 General.--These instructions apply where physicians perform services in a provider setting and have a financial arrangement under which they are compensated by or through a hospital (for both inpatient and outpatient services), or by or through an extended care facility, a home health agency, clinic, rehabilitation agency, or public health agency. These physicians may also be receiving compensation from medical schools or other organizations which have arrangements with the provider for the services they render to provider patients (see § 2108.6).

Further, these instructions apply where modifications of previously existing arrangements between providers and provider-based physicians permit the provider and physician to bill patients separately for their respective services. Such modifications may permit the physician to assume all or part of departmental operating costs. These instructions do not apply to the services of interns and residents; their services are reimbursable to the provider on a reasonable cost basis. (§ 2120).

2108.2 Professional and Provider Components.--

A. Identification of Types of Services for Program Payments.--Many providers retain physicians on a full-time basis in, for example, the fields of pathology, physiatry, anesthesiology, and radiology, and in many instances (especially in teaching hospitals) in other fields of medical specialization as well. Any one of these physicians may be engaged in a variety of activities including teaching, research, administration, supervision of professional or technical personnel, service on hospital committees, and other hospital-wide activities, as well as direct medical services to individual patients. The provider's arrangement may be with a single physician or with a group of physicians who assume joint responsibility for discharging agreed-upon duties.

To make payments under the health insurance program, it is necessary to distinguish between the medical and surgical services rendered by a physician to an individual patient, which are reimbursable under Part B on a reasonable charge basis, and provider services (including a physician's services for the provider) which are reimbursable on a reasonable cost basis, generally under Part A. This is necessary because the payments are made from different trust funds, both fiscal intermediaries and carriers are involved in handling the claims, and the method of determining the payments for Part A benefits differs materially from those under Part B.

B. Distinguishing Between Professional and Provider Components.-- The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly), include two distinct elements, the professional component and the provider component.

The professional component of provider-based physician's services pertains to that part of the physician's activities which is directly related to the medical care of the individual patient. It represents remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment.

The portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient is the provider component. Reimbursement for provider component services can be made only to a provider on the basis of its allowable reasonable costs. Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities. Reimbursement for such services will always be made on a reasonable cost basis, under Part A, where they relate to inpatient services. Reimbursement is under Part B for outpatient services and for inpatient ancillary services where Part A coverage has been exhausted.

Ordinarily the compensation paid to the physician is for all services he performs, in proportion to the time he devotes to each activity. It is a primary obligation of the provider and provider-based physician to mutually agree upon the allocation of compensation for the provider-based physician on the time he spends in his various activities, and to communicate this information with supporting material to the provider's intermediary. The supporting material should include a written explanation of the basis for the allocation agreement.

C. The Provider-Physician Agreement as to Compensation Allocation.-- In some institutions a physician may spend the bulk of his time in duties which benefit the entire patient population and a relatively small part of his time in performing services for individual patients. In other situations, the converse may exist. The arrangement between a provider and a provider-based physician does not generally support a 100 percent allocation of compensation for direct patient services. The allocation in each instance must be based on the facts of the individual case. Each case must be sufficiently documented to support the necessary determination, and should include a written agreement signed by both the provider and physician.

D. Where an Agreement Cannot Be Reached.--Where a provider and physician are unable to reach an agreement as to the allocation of compensation between provider services and direct medical services, the intermediary and carrier will jointly try to resolve this question by meeting with the parties involved, suggesting methods for determining the allocation (e.g., time studies), and otherwise assisting the parties in reaching an accord. If the provider and physician fail to reach agreement within 30 calendar days after this meeting, the intermediary and carrier will jointly establish the required allocation based on their combined experience in comparable provider facilities.

2108.3 Compensation Arrangements.--There are a variety of arrangements between providers and provider-based physicians, the more typical being the fixed compensation arrangement and the variable compensation arrangement. There are also many arrangements under which the physician assumes all or part of the costs of operating the provider department (e.g., lease or concession). Under any of these arrangements, the agreement could stipulate that the physician may bill through the provider for all or part of the services he renders, or that the physician and provider will bill separately for their respective services. It is necessary, therefore, in order to determine the appropriate amount of reimbursement for the services of a physician, to choose the appropriate method to develop the schedule of charges, establish the proper compensation base, and identify which elements of compensation are reimbursable under Part A and which are reimbursable under Part B.

A. The Fixed Compensation Arrangement.--The fixed compensation, usually called a salary or stipend, consists of a specific dollar amount unrelated to volume. It generally covers the physician's provider services as well as his direct medical services to patients. When the computation is carried out, the physician is shown to receive an actual dollar amount which can be determined in advance.

B. The Variable Compensation Arrangement.--Under this type of arrangement, the provider and physician agree that the physician's compensation will be a percentage of departmental gross charges or of net collections. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the provider. The total compensation cannot be determined until the close of the accounting period. The percentage of the combined provider's charge represents the provider's reimbursement to the physician for all services he renders. (Where a physician has a variable income and chooses to use a uniform optional percentage as his schedule of charges, it is not necessary to translate his contract percentage amount into a fixed dollar amount before establishing the optional percentage. The physician's contract percentage multiplied by the professional component allocation will yield the optional percentage.)

C. Additional Elements of a Provider-Based Physician's Compensation.--The following are examples of elements which should be considered in determining the amount of compensation received by a physician for the purpose of establishing a schedule of charges:

1. Fringe Benefits.--When fringe benefits inure to the benefit of the physician, himself, they may be included as part of the physician's compensation. For example, group hospitalization and health insurance premiums paid or incurred by the provider for the benefit of the physician may be included in computing the physician's total compensation. However, if the provider is self-insured, the fringe benefit would accrue to the physician only to the extent of the cost incurred by the provider when health care is furnished. In this case, there would be no fringe benefit inuring to the physician if he receives no health care services from his self-insured employer. On the other hand, where a provider establishes a retirement plan for the benefit of its employees and supplements employee contributions to the fund, if any, with specific amounts that are assignable to individual employees, such amounts may be included in ascertaining the physician's compensation.

2. Compensation From Other Sources.--Some providers have arrangements with medical schools or other organizations under which a physician receives compensation from such organizations for services which the physician renders to the provider patients.

The remuneration of a physician from such sources may be included in determining the total compensation he receives and in establishing the schedule of charges. This remuneration must be allocated between the professional and provider activities of the physician in the same manner as the compensation received from the provider. That portion of remuneration related to teaching or research activities at the medical school itself is not reimbursable under Medicare.

3. Bad Debts.--Bad debts are not to be reflected in determining reasonable charges under the supplementary medical insurance program. The Medicare program reimburses 100 **percent** of the reasonable charges for inpatient hospital radiology and pathology services provided by a physician in the fields of radiology and pathology and 80 **percent** of the reasonable charges for all other medical services after the $50 deductible has been met. The 20 **percent** coinsurance amount and the $50 deductible are considered liabilities of the beneficiary and the provider is deemed not to incur bad debts because of its failure to collect these amounts. Therefore, where a contract stipulates that the physician will receive a percentage of collections (charges minus bad debts), for Medicare reimbursement purposes the percentage should be applied to charges.

4. Payments to Restricted Funds.--Some contracts between provider and physician stipulate that a portion of the physician's compensation is to be transferred to a restricted fund. Where the fund is for replacement of equipment, the amount of the physician's compensation transferred to that fund should not be considered a part of his compensation. An allowance for depreciation, based on asset costs, is a reimbursable provider expense only. However, if amounts assigned to a restricted fund inured solely to the benefit of the physician, e.g., a pension fund, such amounts would properly be included in the physician's compensation.

2108.4 Methods Used to Determine the Reasonable Charge of Provider-Based Physicians.--

A. Consideration Given to Customary and Prevailing Charges.--Reasonable charges for the professional services of provider-based physicians will be determined by the Part B carrier in the same manner as these charges are determined for other physicians and suppliers. Consideration will be given to the customary charges of the provider-based physician for each item of service he renders (see the following sections for an explanation of how such customary charges should be determined) and to the prevailing charge in the locality for similar services rendered in a provider setting.

B. The Schedule of Charges.--The schedule of charges must be designed to yield, in the aggregate, as nearly as may be possible, an amount equal to the portion of the physician's compensation represented by the professional component. There are several methods by which a schedule of charges may be developed based on the provider-based physician's professional component. Principally, these are the "optional," "item-by-item," and "per diem" methods. A variation from any of these methods is acceptable as long as it achieves the same result, i.e., it will yield in the aggregate an amount equal to or approximating the portion of a physician's compensation attributable to direct medical services to patients. Each provider department may use the method it finds most applicable (e.g., the use of the item-by-item method by one department does not prevent the use of the optional method or the per diem method by another department). Where there is more than one hospital-based physician rendering services in a single department, the schedule of charges should be developed for the department as a whole on the basis of the aggregate amount of compensation attributable to the professional components and the aggregate volume of procedures which all physicians in the department are expected to render.

2108.5 Effect of Physician's Assumption of Operating Costs (Lease or Concession Arrangement).--

A. Where the Physician Bills Patients Directly.--
Where a provider initially pays some or all of the operating expenses of a department (e.g., salaries of nonprofessional personnel, supplies and equipment), such operating expenses are reimbursable as reasonable costs to the provider even though the provider is subsequently reimbursed by the physician for the use of those items or services. Such operating expenses are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under the above arrangement are treated as a reduction of allowable costs of the provider reimbursable through the hospital insurance program.

Where a provider-based physician, himself, bears some or all of the costs of operation of a department, the costs which he bears may be reflected in his customary charges and considered in determining reasonable charges under supplementary medical insurance. However, these costs will need to be adjusted upward or downward where the provider has been bearing a cost significantly more or less than its own share of the proceeds of such charges, and the determination of reasonable charges should consider such adjustments.

B. Determination of Reasonable Charges.--The customary charges of a physician who enters into a lease or similar arrangement with a provider, under which the physician assumes the costs of operating a department and bills patients directly, should be based upon: (1) the remuneration he received for his professional services to patients immediately prior to the leasing arrangement; and (2) his reasonable costs of operation, taking into account the provider's cost experience in providing such services. References to the remuneration formerly received by the physician from the provider are required because consideration must be given to the customary charges generally made by the physician for similar services. At the time the lease or similar arrangement became effective, the physician had no pattern of customary charges for his professional services to provider patients other than the compensation he received from the provider. Such compensation, therefore, would serve to establish his customary charges.

C. Where Billing is by or Through the Provider.--Where a physician enters into a lease or concession arrangement and bills through the provider, the services of nonphysicians aiding the physician are reimbursable to the provider on a reasonable cost basis. The amount attributable to the physician's services to the patient is compensable under the supplementary medical insurance program. When submitting a bill to the provider for services rendered, the physician should separately identify in the bill the amounts representing the respective provider and physician components of his services.

2108.6 Duties and Responsibilities of Providers in the Area of Provider-Based Physician Reimbursement.--The effective implementation of provider-based physician reimbursement requires the closest coordination between the provider and its Part A intermediary. The provider is responsible for making available on a timely basis data on the financial and billing arrangements (including contracts, agreements, and other written documentation) it has with its provider-based physicians. This information is necessary to ensure that: (1) Medicare reimbursement for the services of these physicians is made from the appropriate trust funds; (2) the Medicare program does not make duplicate payments for the same service, once as a provider cost and again as a reasonable charge; and (3) the Part B reasonable charge properly reflects any deductible and coinsurance liability of the beneficiary. On a regular basis, the provider should supply the intermediary with any new or revised data which would affect the original reasonable charge determination.

~~to the time he devotes to each activity. It is the pri~~mary obligation of the provider and provider-based physician to mutually agree upon the allocation of compensation for the provider-based physician based on the time the physician spends in his various activities. In the implementation of this provision, the Part A intermediary should obtain a joint statement in writing from the hospital and physician (department head) indicating agreement on the portion of the physician's compensation applicable as a provider cost (Part A) and portion applicable to direct medical and surgical services furnished by the physician to patients. The parties are expected to notify the intermediary about changes in data previously submitted. The Part A intermediary is responsible for reviewing the basis for the agreement to ascertain whether or not it reasonably reflects the activities of the physician and, if the agreement is acceptable, for approving the allocation of the compensation. The portion applicable to the Part B services is then removed from the provider's costs in the cost finding process.

If the intermediary and the carrier are satisfied that the hospital and the physician are in agreement on the separation of their costs, the intermediary will not need to obtain a signed statement; however, the intermediary should have the information supporting the agreement as documentation for the approval of the separation of the provider's and physician's portions of the costs.

2110. BILLING COSTS

2110.1 General.—Generally, billing costs are included in administrative costs and are allocated in the cost finding process to the various cost centers as part of administrative costs. The program then will reimburse providers for its proportionate share of these costs as determined in the apportionment of the costs of the various cost centers.

2110.2 Optional Method of Allocation for Hospitals.—An optional method for determining Medicare's share of billing costs incurred up to January 1, 1968, is provided for *hospitals* to be used at the option of the hospital. The optional method is *not* authorized for other types of providers.

The hospital must remove *all* clerical *billing salaries* from the allowable costs. The portion of those salaries attributable to Medicare billings is added to Medicare's apportioned share of all other allowable costs. All other billing costs are allowable and shared by Medicare in the same manner as other allowable administrative costs.

Example: Provider A

Total clerical billing payroll costs	$ 26,000
Total allowable cost (excluding clerical billing payroll cost)	$900,000
Determination of Medicare Cost	
Medicare's share of clerical billing payroll cost	$ 12,000
Medicare's share of allowable cost (excluding clerical billing payroll cost)	$280,000
Total Medicare cost	$292,000

2110.3 Contract Billing Services.—Where a provider contracts for billing services to be performed by another organization, the contract costs of such services are allowable costs subject, of course, to the provisions of Chapter 10, Cost to Related Organizations. These costs are administrative costs and are subject to cost allocation and apportionment even though the billings contracted out are *Medicare* billings.

2112. NONPHYSICIAN ANESTHETISTS' SERVICES AS HOSPITAL SERVICES

When a nonphysician anesthetist is a salaried member of the staff of a hospital, the services furnished by such an individual in connection with the administration of anesthetic agents are covered in the same manner as the services of other nonphysician hospital employees. Such services to hospital inpatients are covered under Part A as inpatient hospital services. When provided for outpatients, these services are covered under Part B as hospital services incident to a physician's services to outpatients. In either situation, reimbursement for the services furnished is made to the hospital on a reasonable cost basis.

When a nonphysician anesthetist who is not a salaried member of the hospital staff provides services to the hospital's inpatients on a fee-for-service basis, such services are covered in the same manner as the services of a salaried nonphysician anesthetist, providing the nonphysician anesthetist is contractually authorized to furnish such services and the services are made available under arrangements by which payment to the hospital for the service discharges the liability of the patient or any other individual to pay for the services. While the charges for equivalent services of the anesthetist must be uniform for Medicare and non-Medicare patients, billing practices of the nonphysician anesthetist need not be identical for both Medicare and non-Medicare patients in order for the anesthetist's services to be covered in the cases in which the arrangement does meet the requirements specified in guidelines published by intermediaries; that is, these services may be furnished "under arrangements" for Medicare beneficiaries even if the nonphysician anesthetist bills directly for non-Medi-

care beneficiaries. Reimbursement for anesthetist services provided "under arrangements" by which the hospital bills for the services will be made to the hospital on a reasonable cost basis. Services billed directly by a nonphysician anesthetist to an individual patient are not covered under Part A or Part B.

2114. VISITING COSTS OF HOME HEALTH AGENCIES

Costs related to visits for patient care are allowable for reimbursement to the home health agency. Visiting costs are costs incurred relating to making a personal contact in the place of residence of a home health beneficiary by a staff member of the home health agency or by others under arrangements made by the home health agency in order to provide a covered home health service. Such costs also cover outpatient visits made by a patient to a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school to receive covered home health services when arrangements have been made by the home health agency for such services which involve the use of equipment which cannot be made readily available to the patient in his place of residence.

Visiting costs include all incurred costs related to making the visits, such as preparation for the visits, telephone calls or conferences about the patient, maintaining the patients' records, travel to the patients, and treating the patients.

2116. NON-VISITING COSTS OF HOME HEALTH AGENCIES

Non-visiting costs are costs incurred which are related to activities of the home health agency other than home visiting or visits by the patients as an outpatient to a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school for covered hime health services when arrangements have been made by the home health agency for such services which involve the use of equipment which cannot be made readily available to the patient in his place of residence. These costs include costs incurred for the operation of school visit programs, meals-on-wheels program, well-baby clinics, etc. Non-visiting costs are not allowable as costs of the Medicare program.

2118. COST OF SERVICES FURNISHED UNDER ARRANGEMENTS

2118.1 General.—The term "under arrangements" refers to a manner of furnishing services by a provider in which payment to the provider for the services with respect to which the individual is entitled to have payment made by the program discharges the individual's liability to pay for the services. Providers may furnish services "under arrangements" with outside suppliers, including other providers. The amount charged by the supplying organization and paid by the provider for the services rendered then becomes a *cost* to the provider, and is includable in the provider's allowable cost for Medicare purposes to the extent that the costs of such purchased services are determined to be reasonable, subject to the provisions of Chapter 10, Cost to Related Organizations. The reasonableness of the amount is determined by the going rate charged to others for such services within the general community. The services are treated just as though they were furnished directly by the provider.

2118.2 Payment to the Provider.—Where services are provided "under arrangements" the supplier bills, and is paid by, the provider for the services actu ally rendered. Under these circumstances, the Medicare program cannot reimburse the supplier of services directly. Payment for such services is made as a part of provider costs.

a. *Routine services*—The costs of items purchased under arrangements that are considered as a part of covered routine inpatient services are includable in the provider's overall allowable cost for routine services. The costs of routine services will then be apportioned over all patients in accordance with the apportionment method selected. The provider should not bill the program for these purchased services on an individual patient basis, even though the service is actually secured for a specific patient.

b. *Ancillary services*—The supplier should bill the provider for the services purchased under arrangements which are actually rendered, itemizing such services by individual patient and the date of service, and where appropriate the related charge for each service and the quantity of service provided. This bill then provides the supporting documentation for the cost to be included in the provider's allowable cost. The detailed information is then used by the provider to bill the Medicare program for the services provided to each Medicare patient.

2120. REIMBURSEMENT FOR COSTS OF INTERNS AND RESIDENTS

The cost of services of interns and residents provided in facilities with approved teaching programs[1] is includable as a component of allowable cost to the

hospital. Services of interns and residents in such approved programs are excluded from the definition of physicians' medical or surgical services and are covered as hospital services.

Where the beneficiary is an inpatient of a hospital with an approved teaching program or an extended care facility with a hospital approved program and a transfer agreement with the hospital, the cost of the services of interns and residents is included in allowable costs under the hospital insurance program. Where the beneficiary is an outpatient of a hospital, the cost of the diagnostic services rendered prior to April 1, 1968, by interns and residents under an approved teaching program is included in allowable costs under the hospital insurance program.

Services of interns and residents which are covered under Part B on a reasonable cost basis and which are not reimbursable on a reasonable charge basis even though such persons are physicians legally authorized to practice, include:

A. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs,

B. The diagnostic medical and surgical services performed in hospital outpatient departments prior to April 1, 1968, by interns and residents not under an approved teaching program. On and after April 1, 1968, such services are covered under Part B regardless of whether they are under an approved teaching program,

C. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program.

D. The medical and surgical services not covered under Part A performed for extended care facility and home health agency patients by interns and residents (whether or not under an approved program).

For patients who are enrolled under Part B, as indicated by the Reply to the Notice of Admission, the provider will be reimbursed for 80 percent of the cost of providing these services. The provider should collect from the beneficiary 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. As long as the patient is entitled to Part A benefits no determination of the patient's deductible liability need be made for inpatient Part B interns' and residents' services.

Where home health services are furnished by residents or interns under approved teaching programs of the hospital with which the home health agency is affiliated or under common control, the visiting costs incurred by the interns or residents of the hospital for visits to home health beneficiaries are included in the allowable costs of the home health agency.

2122. TAXES

2122.1 General Rule.—The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense should not include fines and penalties, however.

Whenever exemptions to taxes are legally available, the provider is expected to take advantage of them. If the provider does not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable costs under the program.

2122.2 Taxes not Allowable As Costs.—Certain taxes which are levied on providers are not allowable costs. These taxes are:

a. Federal income and excess profit taxes.

b. State or local income and excess profit taxes.

c. Taxes in connection with financing, refinancing, or refunding operations; such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

d. Taxes from which exemptions are available to the provider.

e. Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

f. Taxes on property which is not used in the rendition of covered services.

g. Taxes, such as sales taxes, levied against the patient, and collected and remitted by the provider.

h. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

[1] An "approved program" means approval by the Council on Medical Education of the AMA, by the Committee on Hospitals of the Bureau of Professional Education of the AOA, or by the Council of Dental Education of the ADA. Interns and residents include, in addition to interns and residents-in-training, a physician employed by the hospital who is authorized to practice only in a hospital setting. Further clarification (of approved programs) is included in HIR-4, Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians, Section 405.421.

2124. OXYGEN

Oxygen is classified as a medical supply under both Part A and Part B of the Medicare program, and providers are reimbursed for it on the basis of reasonable cost. When oxygen is furnished to a Medicare inpatient by a participating hospital or extended care facility, or by another under arrangements with such a provider, the cost of oxygen is an allowable Part A cost. Oxygen furnished by a participating hospital as incident to physicians' services to outpatients is an allowable Part B cost. For cost finding purposes, oxygen is classified as a medical supply, part of the *ancillary services* furnished to inpatients under Part A.

The cost of oxygen furnished by a home health agency is covered under Part A as a post-hospital home health service, or under Part B of the program when such oxygen is furnished to a beneficiary in connection with the use of durable medical equipment in his home. Under the provisions for rental or purchase of durable medical equipment this cost is allowable only if oxygen is essential to the effective use of the durable medical equipment, it has been prescribed by the beneficiary's physician, and the equipment has been determined to be medically necessary for the treatment of the patient's condition.

Oxygen is covered under Part B when administered in connection with ambulance services. When the ambulance services are furnished by a provider, payment is made on a reasonable costs basis for the costs of the oxygen in addition to the cost of the ambulance service.

2126. UTILIZATION REVIEW

Utilization review is a *provider* function and reimbursement for utilization review can be made only as a part of the provider's reasonable costs. No payment for utilization review can be made by the program directly to physicians or to utilization review committees. (Section 2126.3). Costs incurred by the provider in connection with utilization review are includable in reasonable costs as set forth in the following sections.

2126.1 Utilization Review in Hospitals.

a. *Physicians' services*—Where utilization review covers the entire patient population of a hospital, payments made to *physicians* for their services on utilization review committees are allowable as costs. Allowable costs are limited to payment of a reasonable compensation to the physician. Such costs are then apportioned among all of the users of the hospital as part of administrative costs. However, where utilization review covers only Medicare beneficiaries, payments made to physicians for their services on utilization review committees are *not* allowable as costs.

b. *Costs other than for physicians' services*—All reasonable costs of utilization review other than for physicians' services are allowable costs and are apportioned among all of the users of the facility. Included in these costs are costs related to the services of professional personnel other than physicians, report writing, etc. Utilization review costs other than for physicians' services are allowable whether or not the utilization review covers the entire patient population.

2126.2 Utilization Review in Extended Care Facilities

a. *Physicians' services*—Payments made to *physicians* for their services on utilization review committees are allowable as costs, whether or not the utilization review covers the entire patient population of the extended care facility. Allowable costs are limited to the payment of a reasonable compensation to the physician.

Where utilization review covers only Medicare beneficiaries, payments made to physicians for their utilization review services performed in calendar years 1967, 1968, and 1969 are reimbursable 100 percent by the Medicare program. Payments made to physicians for services performed after calendar year 1969 are allowable costs and are apportioned among all of the users of the facilitiy.

b. *Costs other than for physicians' services*—Administrative costs related to utilization review and costs of professional personnel other than physicians are allowable costs and are apportioned among all of the users of the ECF, whether or not utilization review covers the entire patient population.

Generally, these costs are allocated as a part of the administrative costs of the facility. However, where utilization review is performed by a committee external to the facility (Section 2126.3) and the ECF is a distinct part of a larger facility, the entire cost of this committee may be charged directly to the distinct part ECF. The costs identified as other than for physicians' services will then be apportioned among the users of the distinct part ECF.

2126.3 Community-Based Utilization Review Committee.--Community-based utilization review committees are those which operate external to the ECF. They are formed primarily by local medical societies or by the intermediary and furnish utilization review services to more than one ECF.

Where this is the case, the organization furnishing the services must bill the ECF for the services. The ECF pays the committee and includes the payment to the committee in its allowable costs under the program. The billing from the committee must be separated into two parts for services furnished in calendar years 1967, 1968, and 1969. One part should indicate the payment made to physicians for their services on the utilization review committee; this part would be treated in accordance with section 2126.2(a) above. The second part should cover all other services and would be treated in accordance with section 2126.2(b) above.

2128. ORIENTATION AND ON-THE-JOB TRAINING

The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be imparted within the provider setting. If, however, the training requires outside instructions, costs of such training are allowable.

2130. LIFE INSURANCE PREMIUMS

Premiums related to insurance on the lives of officers and key employees where the provider is beneficiary are not allowable costs. Premiums related to insurance on the lives of officers and key employees where the individual or his estate is the beneficiary are considered to be compensation to the individual and are allowable costs to the extent such total compensation is reasonable.

2132. START-UP COSTS

2132.1 General.--In the first stages of operation, a new institution incurs certain costs in developing its ability to care for patients prior to the admission of such patients. Staff are obtained and organized, and other operating costs are incurred during this time of preparation which cannot be allocated to patient care during that period because there are no patients receiving services. These preparation costs may be considered to relate to services provided to patients who come into the facility subsequent to the time of preparation, when patient care operations begin. Therefore, it is proper that such costs, commonly referred to as "start-up costs," be considered as deferred charges under the Medicare program and allocated over a number of periods which benefit from such costs.

2132.2 Definition.--For program purposes, "start-up costs" are those costs incurred in the operation and maintenance of an institution from the time the institution is created until the time the first patient, whether Medicare or non-Medicare, is admitted for treatment. These costs include, for example, administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage interest; employee training costs; repairs and maintenance; and any other allowable costs incident to the operation of the facility. In determining "start-up costs," any costs that are properly identifiable as organization expenses or capitalizable as construction costs must be appropriately classified and excluded from "start-up costs."

2132.3 Cost Treatment for Medicare Reimbursement.--

A. Institutions in Existence Prior to July 1, 1966--Where a provider had properly capitalized start-up costs as a deferred charge, amortization of such costs will be recognized as allowable cost (subject to the test of reasonableness) ratably over 60 consecutive months starting with the month in which the first patient is admitted for treatment. Where the provider enters the program more than 60 months after its first patient is admitted for treatment, any existing unamortized start-up costs will not be allowable under the program. Where a provider has an amortization period other than 60 consecutive months on properly capitalized start-up costs, the amortization for program purposes must be recomputed, using a 60-month period starting from the date the provider admitted its first patient for treatment. The following computations illustrate how amortization is recomputed.

Example 1

Facts: A provider enters the program 30 months after it admitted its first patient; start-up costs were properly capitalized in the amount of $30,000; amortization is based on a 120-month period.

	Per Books	Medicare
Start-up costs to be amortized	$30,000	$30,000
Amount amortized to date ($\frac{30}{120}$ x $30,000)	7,500	
Book balance as of date of entry into program	$22,500	
Amount which would have been amortized on a 60-month basis ($\frac{30}{60}$ x $30,000)		15,000
Total amount to be amortized under the program		$15,000

Example 2

Facts: A provider enters the program 24 months after it admitted its first patient; start-up costs were properly capitalized in the amount of $36,000; amortization is based on a 36-month period.

	Per Books	Medicare
Start-up costs to be amortized	$36,000	$36,000
Amount amortized to date ($\frac{24}{36}$ x $36,000)	24,000	
Book balance as of date of entry into program	$12,000	
Amount which would have been amortized on a 60-month basis ($\frac{24}{60}$ x $36,000)		14,400
Total amount to be amortized under the program		$21,600

Start-up costs may not be capitalized retroactively. Where a provider did not capitalize start-up costs, or has written off such costs in the year the expenses were incurred, the provider cannot set up any part of these costs as a deferred charge under the program..

B. **Institutions created on or after July 1, 1966**--Where a provider began operations on or after July 1, 1966, and has properly capitalized start-up costs, they should be amortized ratably over a period of up to 60 consecutive months but not less than 36 consecutive months at the provider's option beginning with the month in which the first patient is admitted for treatment. However, if the start-up costs are considered not material by the intermediary, they may be written off in the first reporting period.

2132.4 **Sale of Institution.**--When a provider institution is sold before the expiration of the amortization period, the portion of start-up costs amortizable through the date of the sale is includable in allowable costs. The unamortized balance of start-up costs after adjustment to the date of the sale will be transferred to the purchaser as an asset. If the purchaser becomes a provider, the unamortized balance of start-up costs transferred in the sale may be amortized and included in allowable cost over the remaining portion of the 60-month period established for amortization by the seller.

2132.5 **Withdrawal from Program.**--Where the provider withdraws from the program, the portion of start-up costs amortizable to the effective date of withdrawal is includable in allowable costs. The unamortized balance of start-up costs is applicable to services provided after the date of withdrawal and, therefore, is not includable in allowable costs.

2132.6 Costs Attributable to Renovation and Expansion Programs.--An institution providing patient care which undergoes a renovation program to qualify for participation under the Medicare program or a provider which expands its existing certified facility by adding a new wing or unit will treat any operating costs applicable to preparing the new facility for operations as costs in the year in which they are incurred. Accordingly, these costs are not subject to deferring and amortization, but are considered allowable operating costs for program purposes, and are apportioned to all users of the institution.

2132.7 Effect on Equity Capital.--The unamortized portion of start-up costs determined in accordance with the provisions of this chapter and allowable for program purposes is includable in the equity capital of the provider.

2132.8 Effective Period of Policy.--The policy stated in this section will be applicable to cost reporting periods ending on or after May 31, 1969.

2134. ORGANIZATION COSTS

2134.1 Definition.--Organization costs are costs incurred in establishing a corporation or other form of organization. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

Expenditures which are considered to be organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization, such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meetings, terms of original stock certificates, necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to the State of incorporation.

Costs connected with issuing or selling shares of stock, or other securities, such as commissions and professional fees, costs connected with the transfer of assets to a corporation, and costs incident to the reorganization of a corporation are not includable in organization costs, but are capital expenditures

Organization costs should be capitalized by the organization. However, if in the opinion of the intermediary these costs are not material, they may be charged into expenses in the first reporting period.

2134.2 **Cost Treatment Under Medicare.**--Where a provider has properly capitalized organization costs, amortization of such costs will be recognized as allowable costs ratably over a period of 60 months beginning with the date of organization. When the provider enters the program more than 60 months after the date of organization, no organization costs will be recognized. Where a provider did not capitalize organization costs and has written off such costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs as an asset under the program.

2134.3 **Amortization Period of 60 Months.**--Where a provider is newly organized upon entering the program and has properly capitalized organization costs, these costs must be amortized ratably over a 60-month period beginning with the date of organization. Where a provider is organized within a 5-year period prior to his entry into the program and has properly capitalized organization costs using a 60-month amortization period, no change in the rate of amortization is required. In this instance, the unamortized portion of organization costs is allowable under the program and is amortized over the remaining part of the 60-month period.

2134.4 **Amortization Period Less Than 60 Months.**--Where a provider has an amortization period less than 60 consecutive months, an adjustment will be necessary for Medicare program purposes. The amortized amount of organization costs must be recomputed using a 60-month period starting from the date the provider was organized. The portion remaining unamortized when the provider enters the program is recognized as an asset under the program and may be amortized over the remaining months of the 60-month period.

Example:

A provider enters the program 24 months after organization; organization costs were properly capitalized in the amount of $12,000; amortization is based on a 36-month period.

	Per Books	Medicare
Organization costs to be amortized	$12,000	$12,000
Amount amortized to date ($\frac{24}{36}$ x $12,000)	8,000	
Book balance unamortized as of date of entry into program	$ 4,000	
Amount which would have been amortized on a 60-month basis ($\frac{24}{60}$ x $12,000)		4,800
Total amount to be amortized under the program		$ 7,200

2134.5 **Amortization Period Greater than 60 Months.**--Where a provider has properly capitalized organization costs prior to entry into the program and has been using an amortization period longer than 60 months, the unamortized amount of organization costs must be recomputed as of the date of entry into the program using a 60-month period starting from the date the provider was initially organized. The amount so computed will be recognized for program purposes and may be amortized over the remaining part of the 60-month period.

Example:

A provider enters the program three years after organization; organization costs were properly capitalized in the amount of $10,000; amortization is based on a 120-month period.

	Per Books	Medicare
Organization costs to be amortized	$10,000	$10,000
Amount amortized to date ($\frac{36}{120}$ x $10,000)	3,000	
Book balance unamortized as of date of entry into program	$ 7,000	
Amount which would have been amortized on a 60-month basis ($\frac{36}{60}$ x $10,000)		6,000
Total amount to be amortized under the program		$ 4,000

2134.6 **Sale of Institution.**--Where the provider institution is sold before the organization costs are fully amortized under the program, the unamortized balance of organization costs on the date of sale will be transferred as an asset to the purchaser. If the purchaser becomes a provider, the unamortized balance of these costs may be amortized over the remaining portion of the 60-month period. The portion applicable to each month will be includable in allowable costs of the reporting period.

2134.7 **Withdrawal from Program.**--Where the provider withdraws from the program, the portion of organization costs amortizable to the date of withdrawal is includable in allowable costs. The unamortized balance of organization costs is not allowable as costs under the Medicare program but is considered applicable to services provided after the date of withdrawal.

2134.8 **Effect on Equity Capital.**--The unamortized portion of organization costs determined in accordance with the provisions of this chapter and allowable for program purposes is includable in the equity capital of the provider.

2134.9 **Effective Period of Policy.**--The policy stated in this section will be applicable to cost reporting periods ending on or after May 31, 1969.

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Adequate Cost Data and Cost Finding

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Chapter 23

Adequate Cost Data and Cost Finding

2300. PRINCIPLE

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

2302. DEFINITIONS

2302.1 Accrual Basis of Accounting—Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

2302.2 Cash Basis of Accounting—Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

2302.3 Governmental Institutions—A provider of services in which the facility is owned and operated by either a Federal, State, or Local governmental agency.

2302.4 Allocable Costs—An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

2302.5 Applicable Credits—Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the Federal Government to finance hospital activities or service operations should be treated as applicable credits.

2302.6 Charges—Charges refers to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

2302.7 Cost Finding—A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

2302.8 Cost Center—A division, a department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

2302.9 General Service Cost Centers—Those divisions, departments or subdivisions thereof, etc., which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

2302.10 Special Service Cost Centers—Commonly referred to as Ancillary Cost Centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the operating room, radiology, laboratory, etc.

2302.11 Inpatient Cost Centers—Cost centers established to accumulate costs applicable to providing routine and ancillary services of inpatients for the purposes of cost assignment and allocation.

2302.12 Outpatient Cost Centers—Cost centers established to accumulate cost applicable to the care and treatment of outpatients.

2302.13 Outpatient Occasions of Service—Each examination, consultation or treatment received by an outpatient in any service department of a hospital. Such occasions of service should be recorded by individual departments and classified as to emergency room, clinics or private ambulatory.

2302.14 Private Ambulatory — Patients referred to the provider by their private physicians to receive treatment or diagnostic tests in one or more of the ancillary cost centers (special service cost centers) and who do not receive any services in the clinic or the emergency room. Such patients are sometimes referred to as Private Referred Outpatients or Private Outpatients.

2302.15 RCC—The ratio of charges to charges. The bases, or charges, used in the RCC formula varies as to the costs to be allocated. The ratios may be expressed as follows:

a. ratio of beneficiary charges to total charges on a departmental basis. See illustrations in Chapter 22.

b. ratio of beneficiary charges for ancillary services to total charges for ancillary services. See illustrations in Chapter 22.

c. ratio of total patient charges by patient care centers to the total charges of all patient care centers. See Exhibit I–9 of this chapter for an example.

2302.16 Overhead — In the procedures outlined in this chapter, overhead rates are not developed except where such rates are used in the computation of cost per visit used in connection with the National League for Nursing, Method II. In this connection, overhead cost is the total expense of the agency, minus the costs accounted for in nursing services, supervision, transportation and expenses normally considered as indirect cost but chargeable to a direct service through allocation.

2302.17 Home Health Discipline—A branch of learning such as medicine, nursing, physical therapy, etc., each of which requires special skills and training. In cost finding for home health agencies, it is desirable to develop separate visit costs for services provided by the various disciplines. For example, separate visit costs should be developed for nursing, physical therapy, occupational therapy, speech therapy, etc., rather than an overall average visit cost.

2302.18 Home Health Visit—A personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for the furnishing of a covered service on an outpatient basis because it requires the use of equipment which cannot be made readily available in the home.

2304. ADEQUACY OF COST INFORMATION

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made to the intermediary.

2306. COST FINDING METHODS

After the close of the reporting period, one of the following methods of cost finding should be used to determine the actual costs of services rendered during that period.

2306.1 Step-down Method—This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first. Exhibit I illustrates this method.

2306.2 The Double-Apportionment Method—The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers. This method is illustrated in Exhibit II.

2308. COST FINDING METHODS—HOME HEALTH AGENCIES

2308.1 National League for Nursing—Method I—This method separates the home visiting costs from the other nursing services and activities referred to as non-visiting costs, such as clinics, classes, work in school, etc. After deducting non-visiting costs, visiting costs are divided by the total number of home visits to obtain the cost per visit for the reporting period. An acceptable variation of this method is the determination of a separate rate for nursing and a separate rate for home health aides. This method is illustrated in Exhibit IV. For further details of NLN Method I refer to "NLN Cost Analysis for Public Health Nursing Services," Code 21–1159, issued 1964 by the National League for Nursing, Department of Public Health Nursing.

2308.2 National League for Nursing Method I—Revised 1967—Under this method the cost of a specific type of visit is determined, such as physical therapy, speech therapy, or home health aide service visits. It also provides that the cost of skilled nursing visits be refined to differentiate between the cost of a visit for the care of the sick or diseased from the cost of a visit made in the interest of disease prevention or health promotion, based upon a time study. Until Form SSA–1728 is revised, the home health agency may substitute its own worksheets and schedules for Schedule A–3 through A–10. Further details regarding this method may be found in the publication of the Department of Public Health Nursing, National League for Nursing, Inc., Code 21–1267, issued 1967.

2308.3 National League for Nursing—Method II—This is a refinement of the average cost per visit method and may be adapted to obtain costs of many separate activities or services, such as various classification of visits to individuals. The overall cost per visit or the visit cost for each discipline providing the service such as nurse, physical therapist, home health aide, etc., may be determined. Exhibit V illustrates this method. For further details of NLN Method II refer to "NLN Cost Analysis for Public Health Nursing Services," Code 21–1159 issued 1964 by the National League for Nursing, Department of Public Health Nursing.

2308.4 Combined PHS-NLN Method — This procedure finds the cost of a visit by developing the time per work unit through time study and allocation of unidentified costs based upon a ratio of these unidentified costs to total costs excluding salaries.

The following procedures are necessary to determine the cost of each work unit of service:

a. The collection, during a sufficient sample period, usually a month, of data on the amount of time spent on selected units of work.

b. A summary of the time spent by all staff members.

c. A summary of the number of work units performed during the same calendar month as the time study and during the reporting year.

d. Calculation of direct costs and an allocation of the unidentified costs to total costs excluding salaries.

e. The costs for services are then distributed based upon the same proportion as the time spent on the direct service work unit.

For further details on the combined PHS–NLN Method procedure for cost allocation refer to "How to Determine Nursing Expenditures in Small Health Agencies" by Marion Ferguson, R.N., Ph.D., Public Health Service Publication No. 902, revised 1966. This method is illustrated in Exhibit VI.

2310. MORE SOPHISTICATED METHODS

A more sophisticated method designed to allocate cost more accurately may be used by the provider upon approval of the intermediary.

2312. CONSISTENCY OF METHODS

Having elected to use a certain method of cost finding, the provider may not thereafter use another method without approval of the intermediary. A request in writing for such approval must be made on a prospective basis and must be submitted before the end of the fourth month of the reporting period in which the change will be effected. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use a less sophisticated method without similar request and approval.

2320. COST FINDING SCHEDULES

2320.1 General Comments—The cost data submitted must be based on the accrual basis of acounting which is recognized as the most accurate basis for determining costs. Particular attention should be given to accruals in the first reporting period, particularly if the first reporting period is a short period. All accruals of a significant nature must be recorded on the provider records at year end to preclude inequity of cost allocation. Those providers who maintain their records on a cash basis may record such accruals as worksheet adjustments. Significant costs to be represented by accruals include, but are not limited to: employee vacation pay, bonuses, and professional fees. Governmental institutions that operate on a cash basis of accounting may submit cost data on that basis subject to appropriate treatment of capital expenditures. Cents are omitted in the preparation of all worksheets and schedules except when inclusion is required to properly reflect average per diem cost, average cost per visit, average cost per hour, etc. Percentages should be carried 2 places to the right of the decimal point except where different instructions for percentages are specified in home health agency cost forms. Bases other than those recommended for any of the following schedules may be used with the intermediary's approval provided such bases will produce more accurate results. In lieu of the forms provided, the provider may wish to use its own worksheets and schedules. These are acceptable if the information and data are presented in a manner comparable to the required forms and are approved by the intermediary. Cost reports are due on or before the last day of the third month following the close of the accounting period.

2322. FORM SSA–1562 REIMBURSABLE COST ON THE DEPARTMENTAL RCC METHOD OR COMBINATION METHOD (COMPUTED WITH COST FINDING)

This form provides for determining reimbursement using cost finding for hospitals and incorporates the following schedules:

Schedule A. Reclassification of Trial Balance of Expense

Schedule B. Cost Apportionment—General Services

Schedule C. Departmental Cost Apportionment

Schedule D. Cost Per Unit of Service

See §§ 2322.1 to 2322.13 inclusive for explanations of schedules included in Form SSA–1562. For further explanation of calculations and procedures see "Cost Finding for Hospitals" (1957) by the American Hospital Association.

2322.1 SSA–1562 Schedule A—Reclassification of Trial Balance of Expenses—This schedule provides for listing the trial balance of direct expenses as shown by the hospital's general books as follows:

a. Column 1—Salaries

b. Column 2—Other Expenses

c. Column 3—Total Expenses

Column 4 provides for the reclassification of data appearing in Columns 1, 2 and 3 for the purpose of effecting proper cost distribution. Schedules A–1, A–2, A–3 and A–4 support such reclassifications.

Column 5 reflects adjustments to expenses made on Schedule A–5.

Column 6 represents the adjusted expenses to be entered on Worksheet B and apportioned to the patient care costs centers involved. Also, in this column, enter on line 35 the 2% allowance as computed on Form SSA–1563A. This allowance should be combined with administrative and general expense upon transfer to Worksheet B. See § 2322.16 of this chapter for further instructions.

When salaries (Column 1) are used as the base for distributing costs on Worksheet B, such salaries should reflect the reclassifications made on Schedule A–1 through Schedule A–5.

2322.2 SSA–1562 Schedule A–1—Administrative and General Expense Analysis—This schedule provides for separating employee health and welfare benefits from administrative and general expenses. Administrative and general expenses are reduced by the amount of employee health and welfare benefits

and increased by the amount of interest expense where appropriate. The allowance in lieu of specific recognition of other costs should not be shown on Schedule A–1 but should be combined with administrative and general expense when these amounts are transferred from Schedule A to Worksheet B.

2322.3 SSA–1562 Schedule A–2—Dietary Expense Analysis—The purpose of this analysis is to reclassify direct costs of food, and its preparation and handling into the proper cost centers for subsequent allocation to the using departments.

2322.4 SSA–1562 Schedule A–3—Medical-Surgical Expense Analysis—This analysis reclassifies medical and surgical expenses into their proper cost centers for subsequent allocation to using departments.

2322.5 SSA–1562 Schedule A–4—Laboratory Expense Analysis—This analysis serves to segregate costs of the blood bank from other laboratory expenses in order to properly allocate such costs to the departments receiving this service. This analysis is also used where appropriate to segregate costs of Clinical Laboratory from the costs of Pathology Laboratory.

2322.6 SSA–1562 Schedule A–5—Adjustments to Expenses—This schedule reflects adjustments to total patient expenses and supports entries made in column 5, Schedule A, Form SSA–1562. Such adjustments are represented by:

a. Revenues which are actually reductions of expense rather than income (except grants or gifts applicable to specific expenses as discussed in § 2328).

b. Allowable expense not recorded on the provider's general books of account.

c. Expenses which are specifically unallowable except for such expenses to which significant general service costs apply which should be handled as indicated in § 2328.

d. That portion of provider-based physician compensation including fringe benefits not considered to be administrative expense.

2322.7 SSA–1562 Worksheet B—Cost Apportionment—General Services—This schedule employs the use of the step-down method described in "Cost Finding for Hospitals" (1957) by the American Hospital Association. Its accuracy is essential to the validity of final cost determinations and to the determination of the program's share of such costs. Its accuracy is primarily dependent on the propriety of the bases (square feet, hours of service, etc.) used to allocate costs of each department to the department(s) which receive services.

2322.8 SSA–1562 Worksheet B–1—Cost Apportionment—Statistical Basis—This worksheet is used to indicate the basis which will be applied to each cost center and is the basic starting point for allocation of costs of general service departments to other general service departments and to special service departments. The bases shown on the schedule are suggested bases. Other bases which result in a more equitable allocation may be used providing the Intermediary has approved their use. The provider must maintain adequate documentation to support the bases used.

2322.9 SSA–1562 Worksheet B1–1—Apportionment Dietary Raw Food—This schedule provides a basis for the distribution of the costs of raw food to those cost centers which received the benefits. The weighting factor gives effect to differences in the meals served patients and personnel of the respective cost centers.

2322.10 SSA–1562 Worksheet B1–2—Apportionment Dietary—Others—This schedule provides a basis for the distribution of the costs of food preparation and dietary administration costs. Part A of this worksheet provides for the direct apportionment of those other dietary costs which pertain to the cafeteria. Part B provides for the distribution of the balance of dietary costs or if Part A is not necessary the total of the dietary other costs.

2322.11 SSA–1562 Schedule C—Departmental Cost Allocation—After all costs have been stepped down to the departments within the Special Service, Inpatient and Outpatient Cost Centers and Unallowable Cost Centers, they are then allocated on this schedule to the major revenue-producing centers on the basis of:

a. RCCAC—The ratio of charges to charges applied to cost

b. Occasions of service

c. Other basis

In selecting a basis, uniformity and consistency must be observed. For example, if the ratio of charges to charges method is selected and in the absence of permission granted by the intermediary to do otherwise: (a) this method must be used for all cost centers; and (b) used in cost reports for subsequent years.

2322.12 SSA–1562 Schedule C–1—Departmental Cost Allocation—Total Gross Charges to Charges Basis—This schedule determines the ratio of

department charges by type of patient (inpatient, outpatient, etc.) to total departmental gross charges (all patients). The percentages so developed are applied to the accumulated costs on Schedule C to arrive at the distribution of costs between major revenue-producing centers. If any basis, other than RCC, is used for determining the percentages, a separate schedule should be attached to substantiate the distribution.

2322.13 SSA–1562 Schedule D—Cost Per Unit of Service—This schedule provides for determining the average cost for each unit of service. The suggested units of measure should be used wherever possible. If units other than those indicated are used, the change should be indicated where appropriate.

2322.14 SSA–1563 Depreciation Questionnaire (page 9)—This questionnaire provides information which will assist the intermediary in its review of the provider's cost report and must be submitted regardless of which cost report form the provider uses.

2322.15 SSA–1563 Computation of Optional Allowance for Depreciation (page 10)—For all depreciable assets acquired before January 1, 1966, the provider, at its option, may at the time it enters the program choose an allowance for depreciation based on a percentage of operating costs. This option is available to any provider, regardless of whether or not the provider has historical cost records of these assets. However, a provider that has elected to use actual depreciation cannot at a later date switch to the optional allowance.

The gross allowance from line 13 of this form is entered on line 22, Schedule A–5, Form SSA–1562 (see Chapter 1 §§ 124 and 126 for limitations and examples of computations).

23322.16 SSA–1563A Non-Proprietary Providers' Worksheet for Computing Allowance in Lieu of Specific Recognition of Other Costs—This form provides for the computation of non-proprietary providers' allowance in lieu of specific recognition of other costs which is entered on Form SSA–1562 Schedule A, line 35. Upon determining allowable cost it is necessary to deduct interest expenses before applying the 2% allowance. This form may also be used for proprietary providers except that the applicable percentage is 1½% in stead of 2% and the allowable cost must be reduced by both interest expense and the return on equity capital.

2322.17 SSA–1564 "Combination Method (Estimated Percentage Basis)" and SSA–1564A "Gross RCC Method"—These methods provide for separating allowable direct departmental expenses of the hospital between inpatient and outpatient (see § 2328) on some logical bases. Suggested bases for allocating revenue-producing center costs could be "Occasions of Services" as shown in the text "Uniform Hospital Definitions"—American Hospital Association. General Service department costs may be allocated to revenue-producing department direct expenses as illustrated in Exhibit III–2. Other bases used by the hospital will be acceptable, if they are approved by the intermediary as more appropriate, and will produce more accurate results. When total allowable expenses have been segregated according to type for purposes of the "Estimated Percentage Basis" estimated percentages (determined by the intermediary in conjunction with the provider) are applied to the total inpatient expenses to determine the cost of routine inpatient services and the cost of ancillary services.

The trial balance should be taken from the provider's regular accounts and should provide as much detail as is necessary.

These forms provide for the computation of allowance in lieu of specific recognition of other costs at 2% for non-proprietary providers. If a proprietary institution, then 1½% must be used.

2322.18 SSA–1564 and SSA–1564A—Adjustments to Expenses—(see § 2322.6)

2324. COST FINDING SCHEDULES—EXTENDED CARE FACILITIES

2324.1 Form SSA–1751 Reimbursable Cost on the Departmental RCCAC Method or Combination Method—(Computed with Cost Finding)—This form provides cost finding for Extended Care Facilities using the following schedules:

A. Reclassification of Trial Balance of Expenses
B. Cost Apportionment—General Services
C. Departmental Cost Apportionment

Details of these schedules are included in § § 2324.2 through 2324.8 below. Explanation of the cost finding technique is available in "Cost Finding for Hospitals (1957) by the American Hospital Association.

2324.2 SSA–1751 Schedule A—Reclassification of Trial Balance of Expenses—The trial balance should be taken from the provider's regular

accounts and segregated to show salaries and other expenses. It should be noted that whenever the salaries and other expenses are used as the base for distributing costs in other parts of this series of worksheets and schedules, consideration must be given to the salaries and wages that may have been reclassified in column 6 or adjusted in column 5 and therefore will have an impact on the distribution pattern. It may be necessary in certain cases to analyze ledger accounts in order to adjust the classification of the expense. The adjustment to expenses (from Schedule A–1) covering the sales of various services and other credits to specific expense accounts must be entered to determine the net expense for cost apportionment. The total net expenses for cost apportionment less interest is the basis for computing the allowance in lieu of specific recognition of other costs (see lines 34 through 36 of schedule). This allowance should be combined with administrative and general expense when the amounts are transferred from Schedule A to Worksheet B.

2324.3 SSA–1751 Schedule A–1—Adjustments to Expenses—This schedule reflects adjustments to total patient expenses and supports entries made in column 4, Schedule A. Refer to § 2322.2 for the types of adjustments which are to be shown on this schedule.

2324.4 SSA–1751 Schedule A–2—Administrative and General Expense Analysis—The purpose of this schedule is to provide for reclassifying amounts attributable to employee health and welfare which are included in administrative and general expense. It also provides for the addition to administrative and general expense of interest expense, utilization review costs other than physician compensation, and the allowance (1½% or 2%) in lieu of specific recognition of other costs.

2324.5 SSA–1751 Schedule A–3—Analysis of Dietary Raw Food and Dietary—Other Expense Accounts—See § 2322.4 for an explanation of the purpose of this schedule.

2324.6 SSA–1751 Worksheet B—Cost Apportionment General Services—This worksheet is intended for cost finding using the step-down method, referred to as Method II in "Cost Finding for Hospitals" (1957) by the American Hospital Association (see § 2322.7).

2324.7 SSA–1751 Worksheet B–1—Cost Apportionment Statistical Basis—See § 2322.8.

2324.8 SSA–1751 Worksheet B–2—Cost Apportionment—Dietary Raw Food—See § 2322.9.

2324.9 SSA–1751 Schedule C—Departmental Cost Apportionment Gross Charges to Charges Basis—After all costs have been allocated to Special Service, and Inpatient and Outpatient Cost Centers, the total costs of these centers are entered on Schedule C and apportioned between inpatient and outpatient services. The apportionment is made using the ratio of charges to charges applied to cost, on a statistical basis or on some other basis approved by the intermediary.

2324.10 SSA–1750 Schedule B—Depreciation Questionnaire (Part A)—This questionnaire provides information which will assist the intermediary in its review of the provider's cost report, and must be submitted regardless of which cost report form the provider uses.

2324.11 SSA–1750 Schedule B—Computation of the Optional Allowance for Depreciation (Part B)—See § 2322.15.

2324.12 SSA–1750 Schedule H—Cost Per Unit of Service—See § 2322.13.

2324.13 SSA–1752 "Combination Method (Estimated Percentage Basis)" and SSA–1753 "Gross RCCAC Method"—These methods provide for separating allowable direct departmental expenses of the facility between inpatient and outpatient (see § 2328) on some logical bases. Suggested bases for allocating revenue producing cost centers could be "Occasions of Services" as shown in the text "Uniform Hospital Definitions" by the American Hospital Association. Other bases may be used by the facility if they are approved by the intermediary as more appropriate and will produce more accurate results.

When total allowable expenses have been segregated according to type for purposes of the "Estimated Percentage Basis," an estimated percentage (determined by the intermediary in conjunction with the facility) is applied to the total inpatient expenses to separate the cost of routine inpatient services from the cost of ancillary services.

The trial balance should be prepared from the provider's regular accounts and should provide as much detail as possible. Provisions are made on these forms for computing the allowance in lieu of specific recognition of other costs and the analysis

required for the proper segregation of physicians' compensation from utilization review costs.

2324.14 SSA–1752 and SSA–1753 page 2—Adjustments to Expenses—See § 2324.2.

2326. COST FINDING SCHEDULES—HOME HEALTH AGENCIES

2326.1 SSA–1728 Home Health Agency—Statement of Reimbursable Cost—All agencies using the National League for Nursing Method I, National League for Nursing Method II, the combined Public Health Service–National League for Nursing Method or the Ratio of Medicare Charges to Total Charges Applied to Cost Method must use cost report Form SSA–1728 (7/67) to report their reimbursable costs for final settlement for the accounting period.

All agencies must complete the white section of this report consisting of pages 1 through 4 and page 9. In addition, each agency will complete one of the following sets of schedules, depending on the method used in determining costs:

a. NLN Method I (Yellow Section)
b. NLN Method II (Green Section)
c. Combined PHS–NLN Method (Blue Section)
d. RCCAC Method (Pink Section)

2326.2 SSA–1729 Hospital-Based Home Health Agency—Statement of Reimbursable Cost—Hospital-based and extended care facility-based home health agencies must develop home care costs in their step-down or other cost finding procedures by providing a separate cost center for home health care. Hospital cost report, Form SSA–1562, Schedules A through D required for hospital cost reporting should be used to determine the home health agency's direct and indirect costs. Extended care facility-based home health agencies will use the equivalent extended care facility cost report to determine the home health agency's cost. Any refinement to the above method of cost finding used for the hospital or extended care facility as a whole will be acceptable for the home health agency.

For purposes of filing the required cost report, the hospital-based home health agency will transfer the above final accumulated home health center costs to the required reporting Form SSA–1729, Schedules A–1 through A–4. Hospital-based agencies will be reimbursed on the basis of the RCCAC method.

The reporting period of the hospital-based home health agency must be the same as that of the hospital. Copies of related cost schedules filed on behalf of the hospital are to be filed with and considered as part of the cost reports of hospital-based home health agency.

Hospital-based home health agencies which do not maintain a schedule of charges will be precluded from using the RCCAC method of cost reimbursement. The hospitals falling in this category may compute home health service costs by an average cost per visit. Total Medicare visits are multiplied by the average cost per visit to arrive at total Medicare (home health) reimbursable costs. The above formula may be further refined to include an average cost per visit by each type of service.

Hospital-based home health agencies not having a uniform charge structure but using the average cost per visit method of apportionment (NLN Method I) or average cost per visit by type of service (NLN Method II or combined PHS–NLN Method) should use cost reporting Form SSA–1728.

2328. DISTRIBUTION OF GENERAL SERVICE COSTS TO NONALLOWABLE COST AREAS

Nonallowable cost centers to which general service costs apply should be entered on Worksheet B after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine "step-down" process. In the event there are more non-allowable cost centers than Schedule B can presently accommodate, then supplement schedules should be prepared. When the "step-down" process is complete, only allowable costs should be carried forward to Schedule C, Departmental Cost Allocation.

Schedule A–5, Adjustments to Expenses, will continue to be used for: expense recoveries (rebates, refunds, etc.); adjustments based on the income recieved; nonallowable costs to which general service costs are not applicable; and the amount applicable to Part B for hospital-based physicians (unless the contract includes a proportionate share of general service costs). These items will still be carried forward to Schedule A. (See Exhibit III–2.)

The following illustrates how certain types of nonreimbursable costs and adjustments should be handled:

A. *Research*—Where this is a material amount in the circumstances, a separate cost center should be established and the cost, determined on an accrual basis, should be carried forward to Worksheet B so that a proportionate share of general service costs may be distributed to it.

B. *Sale of Scrap, Waste, Etc.*—The income from these items should be used as a reduction of the applicable expense before these expenses receive their share of indirect expenses. If the applicable expense cannot be determined, for expediency the "Operation of Plant" account can be used.

C. *Rebates and Recovery of Expense*—The amount of the rebates or recovery should be used to reduce the applicable expense before these expenses receive their proportionate share of indirect expenses. A grant or gift applicable to a specific expense is not considered a recovery of expense and should not be applied until after the step-down has been completed. In computing the allowance in lieu of specific recognition of other costs (SSA–1563A) the total allowance cost must be reduced by the amount received from the gift or grant *before* computing the 1½% or 2% allowance.

D. *Gift, Flower, and Coffee Shops*—Where cost centers are maintained for these functions, the cost should be carried forward to Workshtet B and receive an allocable share of general service costs. After the allocation is made, the total cost of these functions must be excluded in determining reimbursable cost. In this case, income will not be used to reduce expenses. Where cost centers are not maintained for these functions, the income derived from them must be used to reduce total hospital expense. For expediency, the cost in the "Operation of Plant" account can be reduced.

E. *Amount Applicable to Part B for Hospital-Based Physicians*—Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on Schedule A–5. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate proportion of general service costs.

Those providers who report cost on SSA Form–1564—Combination Method, Estimated Percentage Bases—and SSA Form–1564A—Gross Ratio of Charges to Charges Basis—may determine that portion of general service costs attributable to the nonallowable cost centers in the following manner:

1. Determine the cost of those general service cost centers which directly or indirectly contribute to the functions performed within the nonallowable cost areas.

2. Determine the percentage that the costs of these contributing centers is to the total of all other costs (including nonallowable costs).

3. Apply the resulting percentage to the nonallowable costs to reflect the total adjustment for nonallowable cost.

An example of this calculation and its application is as follows:

Cost Centers Applicable to Nonallowable Cost Areas		Expense Per Books		Adjustments Increases (Decreases)	Adjusted Operating Expenses
Depreciation		$ 90,000			
Employee Health and Welfare		85,000			
Operation of Plant		115,000			
Maintenance of Plant		71,000			
Laundry and Linen Service		61,000			
Housekeeping		122,000			
Maintenance of Personnel		10,000			
Administrative and General		326,000			
Sub-Total	(A)	$ 880,000	(C)	($ 4,181)	$ 875,819
Nonallowable Cost Areas	(B)	10,000	(C)	4,181	
All Other Costs	(B)	2,095,000	(D)	($14,181)	2,095,000
Total Costs		$2,985,000		($14,181)	$2,970,819

$$\frac{(A)\ 880{,}000}{(B)\ 2{,}105{,}000} = 41.81\%$$

(C) $10,000 × .4181 = $4,181 — For expediency, this credit adjustment may be applied to Administrative and General Expense

(D) $10,000 + 4,181 = $14,181

The provider may use any other method which the intermediary has determined will be more accurate in developing the adjustment for nonallowable cost.

2330. REPORTING PERIOD

Cost reports are due on or before the last day of the third month following the close of the provider's accounting period. Specific details as to periods for cost report filing may be found in Chapter 24, § 2414.

2332. ILLUSTRATIVE EXAMPLES

2332.1 Step-Down Method (Using Form SSA–1562 and Related Schedules) Exhibit I—Under the step-down method, costs of the service departments which receive the least service from other departments and provide the greatest service to other departments are distributed first. As the costs of each cost center are distributed that cost center is closed. Each succeeding center's costs are distributed until all general service costs have been allocated to the revenue-producing and nonreimbursable cost centers. Exhibit I has been prepared using hypothetical amounts to demonstrate the application of this method.

2332.2 Double Apportionment Method (Using Worksheet B and B–1 of SSA–1562) Exhibit II—The double apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers or nonallowable cost centers.

A variation of this method acceptable for program purposes is illustrated in Exhibit II. Except for Depreciation and General and Administrative, the first or preliminary apportionment of expenses is made to all cost centers including the center being distributed.

Example: Employee Health and Welfare expenses of $121,081 on Worksheet B (Exhibit II–1).

The cost to be apportioned is arrived at as follows:

Line 3 Column 2	$103,169
Line 3 Column 3	17,912
Cost to be apportioned	$121,081

This cost of $121,081 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–3).

Example: Housekeeping expenses of $95,164 on Worksheet B (Exhibit II–1)

Line 7 Column 2	$74,720
" " " 3	12,973
" " " 4	7,144
" " " 5	108
" " " 6	117
" " " 7	102
Costs to be apportioned	$95,164

This cost of $95,164 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–3) including those nonrevenue-producing centers which preceded it in this allocation.

A portion of the Housekeeping costs is also distributed to the Housekeeping cost center.

In the second or final distribution, the balances are "stepped-down" to both nonrevenue as well as revenue producing cost centers except that each nonrevenue-producing center is closed and no amounts are distributed to centers which preceded it in the allocation.

Example: Employee Health and Welfare expenses of $4,472 on Worksheet B (Exhibit II–2)

The cost to be apportioned is arrived at as follows:

Line 3 Column 2	$4,399
Line 3 Column 3	73
Cost to be apportioned	$4,472

This cost of $4,472 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–4). In this second distribution, no cost is distributed to the Employee Health and Welfare cost centers or any nonrevenue-producing centers preceding it.

2332.3 Combination Method (Estimated Percentage Basis)—Using Form SSA–1564 and Related Schedules—Exhibit III—and Gross RCC Basis—Insofar as the Classification and Adjustment of Hospital Operating Expenses and Adjustments to Expenses are concerned these forms are identical and the same procedures would be followed for both methods. Exhibit III has been prepared using hypothetical amounts to illustrate the Combination Method using the Estimated Percentage Basis (Form SSA–1564).

2334. ILLUSTRATIVE EXAMPLES—HOME HEALTH AGENCIES

For illustration purposes, only those pages of Form SSA–1728 pertaining to cost finding were completed using hypothetical amounts.

All agencies must complete the white section of this report consisting of pages 1 through 4 and page 9. In addition each agency will complete one of the following sets of schedules, depending on the method used in determining costs.

2334.1 National League for Nursing—Method I—Exhibit IV——Those agencies which develop an average cost per visit by procedures developed by the National League for Nursing and known as Method I, or a variation of this method, will complete page 5, Schedule A–4, and Schedule A–5.

2334.2 National League for Nursing—Method II—Exhibit V— Those agencies which develop an average cost per visit by procedures developed by the National League for Nursing and known as Method II which entails determination of the cost of various classifications of home visits and other services by diagnoses and disciplines of the home health agency worker, or a refinement of this method, will complete page 6, Schedule A–6 and Schedule A–7 only if costs are to be reimbursed based on types of services provided.

2334.3 Combined PHS–NLN Method—Exhibit VI—Those agencies which develop an average cost per visit by the method jointly developed by the Public Health Service and the National League for Nursing or a variation of this method, will complete page 7, Schedule A–8.

2334.4 Calculation of HI Program Costs of Home Health Service Based on RCCAC Apportionment—Exhibit VII—Home health agencies which have developed a charge structure which is related to cost and which is systematically applied to services provided may use the Gross RCCAC Method to apportion costs to the Medicare program. Page 8, Schedule 9 and Schedule 10 of Form SSA–1728 must be completed.

2334.5 Home Health Services—Cost Adjustments for Non-Covered Hospital-Based Home Health Services and Direct Expense Analysis—Exhibit VIII—These schedules are used in conjunction with Form SSA–1562 when the agency is hospital-based. The purpose of the Cost Adjustments for Non-Covered Home Health Services is to eliminate from the total costs of operating the home health agency service department the costs of non-covered services as well as costs of activities not in connection with home visits and expenditures not related to the program for which no charges are made. Such eliminations should be made from actual cost records or costs apportioned on the basis of time or number of units or other rational bases. Workpapers must be included to support the non-covered adjustments contained in Schedule A–3. Examples of non-covered costs are meals on wheels (home delivered meals), clinics, conferences, and group teaching not related to Medicare, i.e., well-baby clinics and other non-visiting type of expenditures.

The direct expense analysis provides for an itemization of total direct costs included in the Home Health Cost Center (Form SSA–1562, Column 1 of Worksheet B). Hospitals may substitute their own direct cost itemization in lieu of using the expense groupings listed on Schedule A–4 if they are unable to list such direct costs in the format contained on Schedule A–4.

325-263 O - 68 - 3

STEP-DOWN METHOD

PROVIDER NO. 00-0000

RECLASSIFICATION OF TRIAL BALANCE OF EXPENSES

PERIOD 7/1/66 - 12/31/66

Schedule A

LINE NO.	ACCOUNT	TRIAL BALANCE OF DIRECT EXPENSES			TRIAL BALANCE RECLASSIFIED FOR COST APPORTIONMENT	ADJUSTMENTS TO EXPENSES *Increases and (Decreases)* (See Sch. A-5)	NET EXPENSES FOR COST APPORTIONMENT *
		SALARIES	OTHER	TOTAL	TOTAL		
		1	2	3	4	5	6
1	Administration and General	$ 120,893	$ 207,223	$ 328,116	$ 225,623	$ (2,782)	$ 222,841
2	Employee Health & Welfare Bene.	-	-	-	102,766	-	102,766
3	Dietary – Raw Food	-	127,543	127,543	68,440	-	68,440
4	Dietary – Other Expense	41,676	3,137	44,813	25,096	-	25,096
5	Cafeteria	-	-	-	73.147	(18,149)	54,998
6	Housekeeping	63,013	11,120	74,133	74,133	-	74,133
7	Laundry and Linen	23,959	12,901	36,860	36,860	-	36,860
8	Maintenance of Personnel	3,745	936	4,681	4,681	(1,637)	3,044
9	Operation of Plant	9,207	34,636	43,843	43,843	-	43,843
10	Maintenance of Plant	24,129	22,273	46,402	46,402	-	46,402
11	Nursing Service	437,750	38,065	475,815	475,815	-	475,815
12	Nursing School	24,765	4,717	29,482	29,482	(5,428)	24,054
13	Medical-Surgical Expense	57,722	11,637	69,359	-	-	-
14	Intern-Resident Service	-	-	-	50,000	-	50,000
15	Oxygen Therapy	-	-	-	-	-	-
16	Medical Supplies and Expense	-	-	-	19,359	(2,386)	16,973
17	Pharmacy	8,936	46,914	55,850	55,850	-	55,850
18	Medical Records	23,101	2,855	25,956	25,956	(1,297)	24,659
19	Social Service	3,116	300	3,416	3,416	-	3.416
20	Operating Rooms	52,533	27,042	79,575	79,575	-	79,575
21	Delivery Rooms	6,869	3,539	10,408	10,408	-	10,408
22	Anesthesia	2,698	4,797	7,495	7,495	-	7,495
23	X-Ray	38,170	50,598	88,768	88,768	(24,608)	64,160
24	Laboratory	70,639	29,960	100,599	93,704	(19,482)	74,222
25	Blood Bank	-	-	-	6,895	-	6,895
26	Research - Organized	4,320	1,080	5,400	5,400	-	5,400
27	Physical Therapy	48,734	12,183	60,917	60,917	-	60,917
28	Nursery	-	-	-	5,673	-	5,673
29	Fund Raising	12,994	3,413	16,407	16,407	-	16,407
30	Emergency Service	1,030	226	1,256	1,256	-	1,256
31	Depreciation–Buildings, etc.	-	42,257	42,257	42,257	-	42,257
32	Depreciation–Movable Equipment	-	35,823	35,823	35,823	-	35,823
33	Interest Expense	-	273	273	-	-	-
34	Total Expenses	$ 1,079,999	$ 735,448	$ 1,815,447	$ 1,815,447	$ (75,769)	$ 1,739,678
35	2% Allowance (Column 6) (A)						34,788 (2)
36	Total Net Expenses						$ 1,774,466 (3)

*NOTE: Transfer the amounts on lines 1 through 36, Column 6, above, to Column 1, Worksheet B.
If hospital practice provides for combining certain of the above amounts this will be acceptable. The prevailing basis for allocation for the center in which combined should be used.

(1)

FORM SSA-1562 (6-66) (A) Show computation on Form SSA-1563A

(1) From Schedule A-5
(2) Form SSA-1563A
(3) To Worksheet B

Rev. 4

23-15

EXHIBIT I

STEP-DOWN METHOD

PROVIDER NO. 00-0000 EXHIBIT I-1

ADMINISTRATION AND GENERAL EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66 Schedule A-1

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 1, Columns 1, 2 and 3, Schedule A)*	$ 120,893	$ 207,223	$ 328,116
2.	Personnel Department	9,506	635	10,141
3.	Employee Health Service	10,867	2,152	13,019
4.	Hospitalization Insurance		5,755	5,755
5.	Workmen's Compensation		10,550	10,550
6.	Employee Group Insurance		2,877	2,877
7.	Social Security Taxes		36,446	36,446
8.	Annuity Premiums, Past Service Benefits, and Pensions voted by Governing Board		23,978	23,978
9.	Total Employee Health and Welfare *(lines 2 thru 8; to Sch. A. line 2. Column 4)*	$ 20,373	$ 82,393	$ 102,766
10.	Remaining Administration and General	$ 100,520	$ 124,830	$ 225,350
11.	Interest *(from Schedule A Column 3, line 33)* and Other Expense to be added to Administration and General for cost allocation		273	273
12.	Interest expense and remaining administration and general expenses and other expenses *(line 10 +11; to Schedule A. line 1. Column 4)*	$ 100,520	$ 125,103	$ 225,623

DIETARY EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66 Schedule A-2

A. Analysis of Dietary–Raw Food:

	Value of Raw Food *(From line 3, column 2, Schedule A)*		$ 127,543
	Issued to or prepared for use in:		
1	Cafeteria	$ 53,430	
2	Nursery	5,673	
3	Dietary–Raw Food	68,440	
4	TOTAL *(Same as line A)*		$ 127,543

B. Analysis of Dietary–Other *(from line 4, Columns 1, 2 and 3, Schedule A)*

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Cafeteria	$ 18,337	$ 1,380	$ 19,717
2.	Dietary	23,339	1,757	25,096
3.	TOTAL	$ 41,676	$ 3,137	$ 44,813

C. Summary of Analysis:

Dietary–Raw Food *(from A, line 3 above)* *(to appear on line 3 in Column 4, Schedule A)*		$ 68,440
Dietary–Other–Salaries *(from B, line 2, column 1 above)*		
Salaries		$ 23,339
Other expense *(from B, column 2, line 2 above)*		1,757
Total–Other *(to line 4, Column 4, Schedule A)*		$ 25,096
Cafeteria		
Salaries *(from B, column 1, line 1 above)*		$ 18,337
Raw food *(from A, line 1, above)*	$ 53,430	
Other *(from B, column 2, line 1 above)*	1,380	
Total Other		54,810
Total Salaries and Other *(to Line 5, Column 4, Schedule A)*		$ 73,147
Nursery *(from A, line 2 above) (to line 28. Column 4, Schedule A)*		$ 5,673

FORM SSA-1562 (9-66)

PROVIDER NO. 00-0000

MEDICAL-SURGICAL EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66

Schedule A-3

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 13, Columns 1, 2 and 3, Schedule A)*	$ 57,722	$ 11,637	$ 69,359
2.	Intern-Resident Service *(to line 14, Column 4, Schedule A)*	$ 50,000	$	$ 50,000
3.	Oxygen Therapy *(to line 15, Column 4, Schedule A)*	-		-
4.	Medical Supplies and Expense *(to line 16, Column 4, Schedule A)*	7,722	11,637	19,359
5.				
6.	Total Transferred *(Same as line 1 above)*	$ 57,722	$ 11,637	$ 69,359

LABORATORY EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66

Schedule A-4

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 24, Columns 1, 2 and 3, Schedule A)*	$ 70,639	$ 29,960	$ 100,599
2.	Blood Bank *(to line 25, Column 4, Schedule A)*	$ 3,172	$ 3,723	$ 6,895
3.				
4.	Remaining Laboratory *(to line 24, Column 4, Schedule A)*	67,467	26,237	93,704
5.	Total Transferred *(same as line 1 above)*	$ 70,639	$ 29,960	$ 100,599

STEP-DOWN METHOD

EXHIBIT I-3

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Schedule A-5

ADJUSTMENTS TO EXPENSES

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT*	AMOUNT	EXPENSE CLASSIFICATION ON SCHEDULE A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin & Gen	1
2.	Radio and television service	B	(594)	Admin & Gen	1
3.	Laundry and Linen Service				7
4.	Vending Machines Commission				9
5.	Employee and guest meals	B	(18,149)	Dietary	5
6.	Sale of drugs to other than patients				17
7.	Sale of medical and surgical supplies to other than patients				16
8.	Sale of medical records and abstracts	B	(1,297)	Medical Records	18
9.	Sale of scrap, waste, etc.	B	(1,484)	Admin & Gen	1
10.	Rental of quarters to employees and others	B	(1,637)	Maint. of Personnel	8
11.	Rental of hospital space				9
12.	Payments received from specialists				1
13.	Trade, quantity, time, and other discounts on purchases	B	(2,386)	Medical Supplies and Expense	16
14.	Rebates and refunds of expenses				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				1
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	Nursing School	12
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	23 24
21.	Fund raising expenses				Various
22.	Depreciation				31/32
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	TOTAL		$ (75,769)		

FORM SSA-1562 (9-66)

*BASIS FOR ADJUSTMENT:
A – Cost
B – Amount Received

To Sch A

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
			BLDG. AND FIXTURES, ETC.	MOVABLE EQUIPMENT								
		1	1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers											
1a	Provision for Depreciation – Bldg. & Fixtures	$ 42,257	$ 42,257									1a
1b	Provision for Depreciation – Movable Equip.	35,823		$35,823								1b
2	Administration & General	257,629	2,887	2,006	$ 262,522	$262,522						2
3	Employee Health & Welfare	102,766	297	106	103,169	17,913	$121,082					3
4	Operation of Plant	43,843	494	680	45,017	7,816	1,162	$ 53,995				4
5	Maintenance of Plant	46,402	249	574	47,225	8,200	3,046	349	$ 58,820			5
6	Laundry and Linen Service	36,860	1,139	541	38,540	6,692	3,025	1,594	1,748	$ 51,599		6
7	Housekeeping	74,133	71	513	74,717	12,973	7,955	100	110	124	$ 95,979	7
8	Dietary–Raw Food	68,440	-	-	68,440	11,883	-	-	-	-	-	8
9	–Other	25,096	1,298	291	26,685	4,633	2,946	1,817	1,992	519	-	9
10	Cafeteria	54,998	1,354	1,248	57,600	10,001	2,315	1,895	2,078	372	-	10
11	Maintenance of Personnel	3,044	7,695	485	11,224	1,949	473	10,769	11,808	1,533	11,627	11
12	Nursing Service	475,815	462	481	476,758	82,779	55,262	647	709	420	-	12
13	Medical Supplies & Expense	16,973	266	895	18,134	3,149	975	372	408	100	730	13
14	Pharmacy	55,850	197	493	56,540	9,817	1,128	276	302	22	730	14
15	Medical Records	24,659	262	462	25,383	4,407	2,916	367	403	16	2,944	15
16	Social Service	3,416	138	200	3,754	652	393	193	211	143	730	16
17	Nursing School	24,054	1,169	2,091	27,314	4,743	3,126	1,636	1,793	758	4,501	17
18	Intern-Resident Service	50,000	852	269	51,121	8,876	6,312	1,193	1,308	885	-	18
19	Organized Research	5,400	40	9	5,449	946	545	55	61	24	167	19
20	Fund Raising Activities	16,407	138	355	16,900	2,934	1,640	194	213	72	405	20
	Special Service Cost Centers											
21	Operating Rooms	79,575	1,979	6,430	87,984	15,277	6,632	2,770	3,037	11,220	337	21
22	Delivery Rooms	10,408	853	710	11,971	2,079	867	1,194	1,309	3,223	1,657	22
23	Anesthesia	7,495	11	469	7,975	1,385	341	16	17	369	-	23
24	X-Ray	64,160	941	1,729	66,830	11,604	4,819	1,317	1,444	915	2,944	24
25	Laboratory	74,222	1,114	875	76,211	13,233	8,517	1,559	1,710	23	2,351	25
26	Blood Bank	6,895	173	450	7,518	1,305	400	242	266	18	338	26
27	Oxygen Therapy	-										27
28	Physical Therapy	60,917	537	786	62,240	10,809	6,157	752	824	1,328	2,757	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients		13,141	11,094	24,235	4,208		18,388	20,162	24,849	56,736	32
33	Nursery	5,673	1,301	282	7,256	1,260		1,821	1,997	3,413	1,118	33
	Outpatient Cost Centers											
34	Outpatients		2,780	405	3,185	553		3,892	4,267	842	4,594	34
35	Emergency	1,256	419	894	2,569	446	130	587	643	201	1,293	35
36	Private Ambulatory											36
37	TOTAL	$1,774,466	$ 42,257	$35,823	$1,774,466	$262,522	$ 121,082	$ 53,995	$ 58,820	$ 51,599	$ 95,979	37

FORM SSA-1562 (6-68)

From Sch A
Page 1

PERIOD: 7/1/66 - 12/31/66

Worksheet B

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2thru 19, Lines 21-37) (To Sched. C)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a													1a
1b													1b
2													2
3													3
4													4
5													5
6													6
7													7
8	$ 80,323												8
9	594	$ 39,186											9
10	660	324	$ 75,245										10
11	137	68	376	$ 49,964									11
12	14,545	7,149	42,212	5,047	$685,528								12
13	248	122	677	-	7,541	$ 32,456							13
14	302	149	903	-	-	-	$ 70,169						14
15	770	378	2,257	-	7,541	-	-	$47,382					15
16	110	54	301	505	-	-	-	-	$ 7,046				16
17	825	405	2,408	17,664	32,219	-	-	-	-	$ 97,392			17
18	1,650	811	4,816	25,739	-	-	-	-	-	-	$102,711		18
19	-	-	-	-	-	-	-	-	-	-	-	$ 7,247	19 (1)
20	-	-	-	-	-	-	-	-	-	-	-	22,358	20 (1)
21	1,760	865	5,117	-	54,157	4,055	8,521	-	-	10,323	18,850	230,925	21 (2)
22	220	108	602	-	23,308	3,052	3,780	-	-	9,034	13,432	75,836	22 (2)
23	83	41	226	-	-	-	9,633	-	-	-	-	20,086	23 (2)
24	1,265	622	3,687	-	26,050	-	2,581	-	-	-	-	124,078	24 (2)
25	2,255	1,108	6,546	-	30,849	-	1,454	-	-	-	-	146,026	25 (2)
26	110	54	301	-	4,799	-	-	-	-	-	-	15,351	26 (2)
27													27
28	1,622	797	4,741	1,009	15,082	1,656	-	-	-	-	-	109,774	28 (2)
29													29
30													30
32	53,107	26,102	-	-	361,275	20,805	35,873	38,853	7,046	65,975	67,948	825,562	32 (2)
33	33	16	-	-	35,646	1,070	2,897	474	-	7,411	2,481	66,893	33 (2)
34					76,093	97	2,186	6,634	-	4,201	-	106,544	34 (2)
35	27	13	75		10,968	1,721	3,244	1,421	-	448	-	23,786	35 (2)
36													36
37	* $ 80,323	** $ 39,186	** $ 75,245	$ 49,964	$685,528	$ 32,456	$ 70,169	$47,382	$ 7,046	$ 97,392	$102,711	$1,774,466	37
												Exclusions 29,605	(1)
												$1,744,861	(2)

*From Worksheet B-1-1 **From Worksheet B-1-2

(2) To Sch C

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING (Hours of Service)	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers										
1a	Provision for Depreciation: Bldg. & Fixtures	213,150									1a
1b	Provision for Depreciation: Movable Equip.		414,043								1b
2	Administration and General	14,564	23,182		1,511,944						2
3	Employee Health and Welfare	1,500	1,220		103,169	959,106					3
4	Operation of Plant	2,490	7,860		45,017	9,207	194,596				4
5	Maintenance of Plant	1,256	6,639		47,225	24,129	1,256	193,340			5
6	Laundry and Linen Service	5,746	6,252		38,540	23,959	5,746	5,746	647,100		6
7	Housekeeping	360	5,925		74,717	63,013	360	360	1,556	63,118	7
8	Dietary–Raw Food				68,440						8
9	–Other	6,549	3,360		26,685	23,339	6,549	6,549	6,510		9
10	Cafeteria	6,830	14,427		57,600	18,337	6,830	6,830	4,666		10
11	Maintenance of Personnel	38,813	5,610		11,224	3,745	38,813	38,813	19,224	7,646	11
12	Nursing Service	2,332	5,559		476,758	437,750	2,332	2,332	5,268		12
13	Medical Supplies and Expense	1,341	10,342		18,134	7,722	1,341	1,341	1,254	480	13
14	Pharmacy	993	5,694		56,540	8,936	993	993	270	480	14
15	Medical Records	1,324	5,340		25,383	23,101	1,324	1,324	200	1,936	15
16	Social Service	695	2,316		3,754	3,116	695	695	1,792	480	16
17	Nursing School	5,895	24,175		27,314	24,765	5,895	5,895	9,504	2,960	17
18	Intern-Resident Service	4,300	3,105		51,121	50,000	4,300	4,300	11,103		18
19	Organized Research	200	100		5,449	4,320	200	200	300	110	19
20	Fund Raising Activities	700	4,100		16.900	12,994	700	700	900	266	20
	Special Service Cost Centers										
21	Operating Rooms	9,983	74,314		87,984	52,533	9,983	9,983	140,707	235	21
22	Delivery Rooms	4,302	8,204		11,971	6,869	4,302	4,302	40,425	1,090	22
23	Anesthesia	56	5,421		7,975	2,698	56	56	4,625		23
24	X-Ray	4,748	19,985		66,830	38,170	4,748	4,748	11,472	1,936	24
25	Laboratory	5,620	10,109		76,211	67,467	5,620	5,620	2,921	1,546	25
26	Blood Bank	873	5,202		7,518	3,172	873	873	227	222	26
27	Oxygen Therapy										27
28	Physical Therapy	2,709	9,083		62,240	48,734	2,709	2,709	16,660	1,813	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients	66,267	128,233		24,235		66,267	66,267	311,628	37,312	32
33	Nursery	6,564	3,265		7,256		6,564	6,564	42,802	735	33
	Outpatient Cost Centers										
34	Outpatients	14,025	4,689		3,185		14,025	14,025	10,564	3,021	34
35	Emergency	2,115	10,332		2,569	1,030	2,115	2,115	2,522	850	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$ 42,257	$ 35,823	$	$ 262,522	$ 121,082	$ 53,995	$ 58,820	$ 51,599	$ 95,979	37
38	Unit Cost Multiplier	.19825	.08652		.17363	.12624	.27747	.30423	.07974	1.52063	38

FORM SSA-1562 (9-66)

*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

PERIOD 7/1/66 - 12/31/66 Worksheet B-1

LINE NO.	DIETARY RAW FOOD Weighted (Meals Served)	DIETARY OTHER Weighted (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
1a												1a
1b												1b
2												2
3												3
4												4
5												5
6												6
7												7
8	1,143,476											8
9	1 8,456	1,135,020										9
10	9,395	9,395	93,394									10
11	1,955	1,955	467	99								11
12	207,060	207,060	52,393	10	413,263							12
13	3,525	3,525	840		4,546	18,071						13
14	4,305	4,305	1,121				53,387					14
15	10,960	10,960	2,801		4,546			100%				15
16	1,565	1,565	374	1								16
17	11,745	11,745	2,989	35	19,423					88,982		17
18	23,485	23,485	5,978	51							61,175	18
19												19
20												20
21	25,050	25,050	6,351		32,648	2,258	6,483			9,432	11,227	21
22	3,130	3,130	747		14,051	1,699	2,876			8,254	8,000	22
23	1,175	1,175	281				7,329					23
24	18,005	18,005	4,576		15,704		1,964					24
25	32,095	32,095	8,125		18,597		1,106					25
26	1,565	1,565	374		2,893							26
27												27
28	23,095	23,095	5,885	2	9,092	922						28
29												29
30												30
32	756,050	756,050			217,790	11,584	27,294	82%	100%	60,278	40,470	32
33	470	470			21,489	596	2,204	1%		6,771	1,478	33
34					45,872	54	1,663	14%		3,838		34
35	390	390	92		6,612	958	2,468	3%		409		35
36												36
37	$ 80,323	$ 39,186	$75,245	$ 49,964	$ 685,528	$ 32,456	$ 70,169	$ 47,382	$ 7,046	$ 97,392	$ 102,711	37
38	.07025	.034524	.80567	504.68687	1.65882	1.79603	1.31435	47,382	7,046	1.09451	1.67897	38

STEP-DOWN METHOD

EXHIBIT I-6

PROVIDER NO. 00-0000

COST APPORTIONMENT – DIETARY–RAW FOOD (Omit Cents)	PERIOD 7/1/66 - 12/31/66	Worksheet B-1-1

Computation of the amount of cost to be allocated to each "weighted" meal served, listed in Column 1 or Column 3, below.

Dietary–Raw Food *(from line 8, Col. 9 of Worksheet B)* $ 80323 / 1143476 Total Meals Served *(from total of Col. 1 or Col. 3, below)* = $.0702 Per Meal

WORK SHEET B LINE NO.	COST CENTER	STATISTICAL DATA *(Meals Served)*	WEIGHTING FACTOR	MEALS SERVED "WEIGHTED" AS TO DIFFERENCE	COST APPORTIONMENT
		1	2	3	4
9	Dietary–Other	2,114	4	8,456	$ 594
10	Cafeteria	1,879	5	9,395	660
11	Maintenance of Personnel	391	5	1,955	137
12	Nursing Service	41,412	5	207,060	14,545
13	Medical Supplies & Expense	705	5	3,525	248
14	Pharmacy	861	5	4,305	302
15	Medical Records	2,192	5	10,960	770
16	Social Service	313	5	1,565	110
17	Nursing School	2,349	5	11,745	825
18	Intern-Resident Service	4,697	5	23,485	1,650
21	Operating Rooms	5,010	5	25,050	1,760
22	Delivery Rooms	626	5	3,130	220
23	Anesthesia	235	5	1,175	83
24	X-Ray	3,601	5	18,005	1,265
25	Laboratory	6,419	5	32,095	2,255
26	Blood Bank	313	5	1,565	110
28	Physical Therapy	4,619	5	23,095	1,622
32	Inpatients	151,210	5	756,050	53,107
33	Nursery	470	1	470	33
34	Outpatients				
35	Emergency	78	5	390	27
37	TOTAL	229,494		1,143,476	$ 80,323

NOTE: Weighting factor for meals may be used if present practice, otherwise regular meal count may be used.

FORM SSA-1562 (9-66)

To Worksheet B-1, Col. 9

To Worksheet B, Col. 9

STEP-DOWN METHOD

EXHIBIT I-7

PROVIDER NO. 00-0000

COST APPORTIONMENT – DIETARY–OTHER (Omit Cents)	PERIOD 7/1/66-12/31/66	Worksheet B-1-2

PART A – DETERMINATION OF THE PORTION OF DIETARY – OTHER COST TO BE DISTRIBUTED TO CAFETERIA REPRESENTING FOOD PREPARATION AND DIETARY ADMINISTRATION SERVICES

1. Total Food Preparation and Dietary Administration Costs–per Analysis of Dietary Expense Accounts	
Dietary Office–Supplies and Expense	$
Dietary Administration–Salaries and Wages	
General Food Preparation–Salaries and Wages	
General Food Preparation–Supplies and Expense	
TOTAL *(To Formula Below)*	$

2. Computation of the Percentage of Raw Food Distributed to the Cafeteria	AMOUNT	PERCENT
Value of Raw Food Distributed to, or used by Cafeteria *(from Schedule A-2, line 1)*	$	
Value of Raw Food Distributed to, or used by Dietary *(from Schedule A-2, line 3)*		
TOTAL	$	

3. Amount of Dietary Cost to be Distributed to Cafeteria

$	×	%	=	$
TOTAL DIETARY FOOD PREPARATION AND ADMINISTRATION COST – FROM ABOVE		PERCENTAGE OF VALUE OF RAW FOOD USED BY CAFETERIA		AMOUNT OF DIETARY COST TO BE DISTRIBUTED TO THE CAFETERIA *(enter on line 2, Part B, below)*

PART B

1. Total Accumulated Dietary–Other costs to be Distributed *(from line 9, Column 10, Worksheet B)*	$
2. Less Amount to be Distributed to Cafeteria (as determined in Part A, above) *(to line 10, Col. 10, Worksheet B)*	
3. Balance of Dietary–Other costs still to be Distributed per computation below.	$

DISTRIBUTION OF THE BALANCE OF DIETARY–OTHER COSTS:

Computation of the amount of cost to be allocated for each meal served, listed in Column 1, below.

Accumulated Dietary–Other costs to be Distributed: *(from line 3, above)* $ 39,186 / 1,135,020 = $.03452 per meal "Weighted"

Total Meals Served *(from total of Column 1, below)* 39,186 / 229,494 = $.17075 average cost per meal

WORK SHEET B LINE NO.	DEPARTMENT OR ACTIVITY	STATISTICAL DATA *(Meals Served)* "Weighted" 1	COST APPORTIONMENT 2
10	Cafeteria	9,395	$ 324
11	Maintenance of Personnel	1,955	68
12	Nursing Service	207,060	7,149
13	Medical Supplies and Expense	3,525	122
14	Pharmacy	4,305	149
15	Medical Records	10,960	378
16	Social Service	1,565	54
17	Nursing School	11,745	405
18	Intern-Resident Service	23,485	811
21	Operating Rooms	25,050	865
22	Delivery Rooms	3,130	108
23	Anesthesia	1,175	41
24	X-Ray	18,005	622
25	Laboratory	32,095	1,108
26	Blood Bank	1,565	54
28	Physical Therapy	23,095	797
32	Inpatients	756,050	26,102
33	Nursery	470	16
34	Outpatients		
35	Emergency	390	13
37	TOTAL	1,135,020	$ 39,186
		To Worksheet B-1, Col. 10	To Worksheet B, Column 10

FORM SSA-1562 (9-66)

PROVIDER NO. 00-0000

DEPARTMENTAL COST ALLOCATION (Omit Cents)
(For Basis see Worksheet C-1 – Page 10)

PERIOD: 7/1/66 12/31/66

Schedule C

DISTRIBUTION BASIS: [X] RATIO OF CHARGES TO CHARGES APPLIED TO COST [] STATISTICAL (OCCASIONS OF SERVICE) IF CHECKED, FURNISH DETAIL SCHEDULES [] OTHER

LINE NO.	COST CENTER	ACCUMULATED COSTS (from Column 20, lines 21 to 37 of Worksheet B)	INPATIENTS	NURSERY	OUTPATIENTS	EMERGENCY	PRIVATE AMBULATORY
		1	2	3	4	5	6
1	SPECIAL COST CENTERS Operating Rooms	$ 230,925	$ 227,579	$	$ 670	$	$ 2,676
2	Delivery Rooms	75,836	75,836				
3	Anesthesia	20,086	17,899	379	362		1,446
4	X-Ray	124,078	89,518	1,756	6,561		26,243
5	Laboratory	146,026	132,611		2,682		10,733
6	Blood Bank	15,351	14,345		201		805
7	Oxygen Therapy						
8	Physical Therapy	109,774	98,725		2,210		8,839
9	Cost of Medical Supplies Sold						
10	Cost of Drugs Sold						
	INPATIENT COST CENTERS						
11	Inpatients	825,562	825,562				
12	Nursery	66,893		66,893			
	OUTPATIENT COST CENTERS						
13	Outpatients	106,544			89,497		17,047
14	Emergency	23,786				23,786	
15	Private Ambulatory	–	–	–	–	–	–
16	TOTAL	$ 1,744,861	$ 1,482,075	$ 69,028	$ 102,183	$ 23,786	$ 67,789

FORM SSA-1562 (9-66)

Form SSA 1563 Page 2

Sum to Form SSA-1563 Page 3, line 4

STEP-DOWN METHOD

EXHIBIT I-9

PROVIDER NO. 00-0000

DEPARTMENTAL COST ALLOCATION (Omit Cents)
TOTAL GROSS CHARGES TO CHARGES BASIS *(Applied on Schedule C)*

PERIOD 7/1/66 - 12/31/66

Schedule C-1

LINE NO.	COST CENTER	TOTAL GROSS CHARGES *(All Patients)*	TOTAL GROSS CHARGES *(All Inpatients)*	TOTAL GROSS CHARGES *(All Nursery)*	TOTAL GROSS CHARGES *(All Outpatients)*	TOTAL GROSS CHARGES *(All Emergency)*	TOTAL GROSS CHARGES *(All Private Ambulatory)*
		1	2	3	4	5	6
	SPECIAL COST CENTERS		$ 198,160	$	$ 583	$	$ 2,331
1	Operating Rooms	201,074	% 98.551	%	% 00.290	%	% 01.159
			$ 27,360	$	$	$	$
2	Delivery Rooms	27,360	% 100.0	%	%	%	%
			$ 18,892	$ 400	$ 382	$	$ 1,526
3	Anesthesia	21,200	% 89,113	% 1.887	% 01.802	%	% 07.198
			$ 127,728	$ 2,505	$ 9,361	$	$ 37,445
4	X-Ray	177,039	% 72.147	% 1.415	% 05.288	%	% 21.150
			$ 165,763	$	$ 3,354	$	$ 13,416
5	Laboratory	182,533	% 90.813	%	% 01.837	%	% 07.350
			$ 15,782	$	$ 221	$	$ 886
6	Blood Bank	16,889	% 93.445	%	% 01.309	%	% 05.246
			$	$	$	$	$
7	Oxygen Therapy		%	%	%	%	%
			$ 106,583	$	$ 2,386	$	$ 9,543
8	Physical Therapy	118,512	% 89.935	%	% 02.013	%	% 08.052
			$	$	$	$	$
9	Cost of Medical Supplies Sold		%	%	%	%	%
			$	$	$	$	$
10	Cost of Drugs Sold		%	%	%	%	%
	INPATIENT COST CENTERS		$ 904,248				
11	Inpatients	904,248	% 100.00	—	—	—	—
				$ 60,000			
12	Nursery	60,000	—	% 100.00	—	—	—
	OUTPATIENT COST CENTERS				$ 103,616	$	$ 19,736
13	Outpatients	123,352	—	—	% 84.000	%	% 16.000
					$	$ 26,015	$
14	Emergency	26,015	—	—	%	% 100.00	%
					$	$	$
15	Private Ambulatory		—	—	%	%	%
16	TOTAL	$ 1,858,222	$ 1,564,516	$ 62,905	$ 119,903	$ 26,015	$ 84,883

FORM SSA-1562 (9-66) *Ambulance 9,649

1,867,871

Sources: Charges - Form SSA-1563 Page 2 and 3

*Ambulance is covered by a separate set of reimbursement schedules

STEP-DOWN METHOD

EXHIBIT I-10

PROVIDER NO 00-0000

COST PER UNIT OF SERVICE	PERIOD 7/1/66 - 12/31/66	Schedule D

PART I – SPECIAL SERVICES COSTS

COST CENTER	TOTAL COSTS (from lines 21 to 36, Col. 20 of Worksheet B)	SERVICES RENDERED		AVERAGE COST PER UNIT (Col. 1 ÷ Col. 3)
		UNIT	TOTAL	
	1	2	3	4
SPECIAL SERVICE COST CENTERS				
Operating Rooms	$ 230,925	minutes	529,875	$.43581
Delivery Rooms	75,836	deliveries	1,442	52.59085
Anesthesia	20,086	minutes	345,494	.05814
X-Ray	124,078	films	43,229	2.87025
Laboratory	146,026	examinations	96,522	1.51288
Blood Bank	15,351	transfusions	707	21.71287
Oxygen Therapy		minutes		
Physical Therapy	109,774	treatments	31,789	3.45321
Cost of Medical Supplies Sold		–	–	–
Cost of Drugs Sold		–	–	–
INPATIENT COST CENTERS				
Inpatients	825,562	patient days	25,836	31.95394
Nursery	66,893	newborn days	2,666	25.09115
OUTPATIENT COST CENTERS				
Outpatients	106,544	occasions of service	15,203	7.00809
Emergency	23,786	occasions of service	428	55.57477
Private Ambulatory	–	–	–	–

PART 2 – INPATIENT AND OUTPATIENT COSTS

COST CENTER	TOTAL COSTS (from line 16, Columns 2 to 6 of Schedule C)	SERVICES RENDERED		AVERAGE COST PER UNIT (Col. 1 ÷ Col. 3)
		UNIT	TOTAL	
	1	2	3	4
INPATIENT COST CENTERS				
Inpatients	$ 1,484,210	patient days	25,836	$ 57.44736*
Nursery	66,893	newborn days	2,666	25.09115
OUTPATIENT COST CENTERS				
Outpatients	102,183	occasions of serivce	8,704	11.73977
Emergency	23,786	occasions of service	428	55.57477
Private Ambulatory	67,789	occasions of service	6,499	10.43068

*Includes inpatient daily costs plus ancillary charge

Form Approved
Budget Bureau No. 72-R763

INSERT AS PAGE 9 IN FORM SSA-1563	PROVIDER NO. 00-0000
	PERIOD 7/1/66 - 12/31/66

QUESTIONNAIRE

1. How was depreciation included in cost statement calculated?

☐ Actual ☐ Optional Allowance

If Actual: ☒ Straight Line ☐ Sum-of-Years Digits

☐ Declining Balance

2. Is depreciation funded? ☐ Yes ☒ No

If yes: What Basis? _____

Where recorded? _____

Balance in fund at end of period $ _____

3. Were there any gains or losses on disposals of capital assets during period? ☐ Yes ☒ No

Included in Expenses? ☐ Yes ☒ No

Where? _____ Amounts? _____

NON-PROPRIETARY PROVIDERS' WORKSHEET FOR COMPUTING ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS
(REFER TO PRINCIPLE OF REIMBURSEMENT 1-11) (REG. SEC. 405.428)

PROVIDER NO. 00-0000
PERIOD 7/1/66 - 12/31/66

LINE NO.	DESCRIPTION	AMOUNTS (Omit Cents)
1.	Total allowable cost Form SSA-1562 Page 1, Line 34	$ 1,739,678
2.	Less: Interest expense Form SSA-1562 Page 1, Line 33	273
3.	Allowable cost less interest expense *(line 1 minus line 2)*	$ 1,739,405
4.	Allowance *(2% x line 3)*	$ 34,788

To Form SSA-1562, Page 1

FORM SSA-1563A (12-66)

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
			BLDG. AND FIXTURES, ETC.	MOVABLE EQUIPMENT								
		1	1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers					262,508	121,081	53,939	58,417	50,926	95,164	
1a	Provision for Depreciation – Bldg. & Fixtures	$ 42,257	$ 42,257									1a
1b	Provision for Depreciation – Movable Equip.	35,823		$ 35,823								1b
2	Administration & General	257,629	2,873	2,006	$ 262,508	$	11,261	3,668	3,972	204	6,471	2
3	Employee Health & Welfare	102,766	296	107	103,169	17,912	$ 2,301	378	409	51	666	3
4	Operation of Plant	43,843	507	681	45,031	7,818	1,090	$ 647	701	102	1,142	4
5	Maintenance of Plant	46,402	254	573	47,229	8,200	2,664	324	$ 350	458	571	5
6	Laundry and Linen Service	36,860	1,141	537	38,538	6,691	2,664	1,456	1,577	$ 102	2,569	6
7	Housekeeping	74,133	85	502	74,720	12,973	7,144	108	117	102	$ 190	7
8	Dietary–Raw Food	57,928			57,928							8
9	–Other	41,590	1,198	693	43,481	11,933	2,125	1,529	1,656	390	2,698	9
10	Cafeteria	49,016	1,464	847	51,327	14,585	2,597	1,869	2,024	476	3,297	10
11	Maintenance of Personnel	3,044	7,691	502	11,237	1,951	363	9,817	10,633	1,477	17,320	11
12	Nursing Service	475,815	465	466	476,746	82,773	49,159	593	643	407	1,047	12
13	Medical Supplies & Expense	16,973	254	896	18,123	3,147	848	324	350	102	571	13
14	Pharmacy	55,850	211	502	56,563	9,821	969	270	292	51	476	14
15	Medical Records	24,659	254	466	25,379	4,406	2,543	324	350	51	571	15
16	Social Service	3,416	127	215	3,758	652	363	162	175	153	285	16
17	Nursing School	24,054	1,183	2,078	27,315	4,743	2,785	1,510	1,636	713	2,665	17
18	Intern-Resident Service	50,000	845	251	51,096	8,871	5,570	1,079	1,168	866	1,903	18
19	Organized Research	5,400	42		5,442	945	484	53	58	51	95	19
20	Fund Raising Acts.	16,407	126	322	16,855	2,926	1,452	162	175	102	285	20
	Special Service Cost Centers											
21	Operating Rooms	79,575	1,986	6,448	88,009	15,280	5,933	2,535	2,746	11,101	4,473	21
22	Delivery Rooms	10,408	845	716	11,969	2,078	726	1,079	1,168	3,157	1,903	22
23	Anesthesia	7,495		466	7,961	1,382	242			356		23
24	X-Ray	64,160	930	1,755	66,845	11,606	4,238	1,187	1,285	917	2,094	24
25	Laboratory	74,222	1,099	896	76,217	13,233	7,628	1,402	1,519	204	2,474	25
26	Blood Bank	6,895	169	430	7,494	1,301	363	216	234	51	381	26
27	Oxygen Therapy											27
28	Physical Therapy	60,917	549	788	62,254	10,809	5,448	701	759	1,324	1,237	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients		13,142	11,105	24,247	4,210		16,775	18,169	23,629	29,597	32
33	Nursery	5,673	1,310	286	7,269	1,262		1,672	1,811	3,361	2,950	33
	Outpatient Cost Centers											
34	Outpatients		2,789	394	3,183	553		3,560	3,856	815	6,281	34
35	Emergency	1,256	422	895	2,573	447	121	539	584	153	952	35
36	Private Ambulatory											36
37	TOTAL	$1,774,466	$ 42,257	$ 35,823	$1,774,466	$ 262,508	$121,081	$ 53,939	$ 58,417	$ 50,926	$ 95,164	37

FORM SSA-1562 (6-68)

PROVIDER NO. 00-0000

PERIOD: 7/1/66 - 12/31/66

Worksheet B
First Apportionment

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2 thru 19)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a	57,928	63,812	81,740										1a
1b													1b
2			3,365									28,941	2
3			594									4,399	3
4			396									2,988	4
5			1,385									2,764	5
6			1,781									4,452	6
7			7,125									7,315	7
8	$		3,167									3,167	8
9		$											9
10	5,565		$										10
11			396	$ 53,194									11
12			35,822	5,373	$ 652,563								12
13			594		7,178	$ 31,237							13
14			792				$ 69,234						14
15			1,979		7,178			$42,781					15
16			198	537					$ 6,283				16
17			1,979	18,806	30,670					$92,822			17
18			4,156	27,403							$102,112		18
19												$ 7,128	19
20												21,957	20
21			4,156		51,553	3,905	8,377			9,839	19,197	227,104	21
22			594		22,187	2,936	3,739			8,633	13,989	74,158	22
23			198				9,485					19,624	23
24			3,167		24,797		2,562					118,698	24
25			5,542		29,366		1,454					139,039	25
26			198		5,220							15,458	26
27													27
28			3,958	1,075	14,357	1,593						103,515	28
29													29
30													30
32	52,165	63,812			343,250	20,022	35,378	35,081	6,283	62,840	67,599	803,057	32
33	198				33,932	1,031	2,839	428		7,054	1,327	65,134	33
34					72,434	94	2,215	5,989		3,992		102,973	34
35			198		10,441	1,656	3,185	1,283		464		22,596	35
36													36
37	$ 57,928	$ 63,812	$ 81,740	$ 53,194	$ 652,563	$ 31,237	$ 69,234	$ 42,781	$ 6,283	$ 92,822	$ 102,112	$ 1,774,466	37

EXHIBIT II-2

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
		1	1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers											
1a	Provision for Depreciation – Bldg. & Fixtures	$	$									1a
1b	Provision for Depreciation – Movable Equip.			$								1b
2	Administration & General				$ 28,941	$ 28,941						2
3	Employee Health & Welfare				4,399	73	$ 4,472					3
4	Operation of Plant				2,988	50	45	$ 3,083				4
5	Maintenance of Plant				2,764	46	111	20	$ 2,941			5
6	Laundry and Linen Service				4,452	74	111	91	88	$ 4,816		6
7	Housekeeping				7,315	121	297	7	7	10	$ 7,757	7
8	Dietary–Raw Food				3,167	52	197					8
9	–Other							96	92	37	250	9
10	Cafeteria							117	112	46	306	10
11	Maintenance of Personnel						15	615	590	142	1,608	11
12	Nursing Service						2,045	37	36	39	97	12
13	Medical Supplies & Expense						35	20	19	10	53	13
14	Pharmacy						40	17	16	5	44	14
15	Medical Records						106	20	19	5	53	15
16	Social Service						15	10	10	15	27	16
17	Nursing School						116	95	91	69	247	17
18	Intern-Resident Service						232	67	65	83	177	18
19	Organized Research				7,128	118	20	3	3	5	9	19
20	Fund Raising Activities				21,957	364	60	10	10	10	27	20
	Special Service Cost Centers											
21	Operating Rooms				227,104	3,766	247	159	152	1,069	415	21
22	Delivery Rooms				74,158	1,230	30	67	65	304	177	22
23	Anesthesia				19,624	325	10			34		23
24	X-Ray				118,698	1,968	176	74	71	88	194	24
25	Laboratory				139,039	2,305	317	88	84	20	230	25
26	Blood Bank				15,458	256	15	14	13	5	35	26
27	Oxygen Therapy											27
28	Physical Therapy				103,515	1,716	227	44	42	127	115	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients				803,057	13,315		1,050	1,009	2,276	2,748	32
33	Nursery				65,134	1,080		105	101	324	274	33
	Outpatient Cost Centers											
34	Outpatients				102,973	1,707		221	214	78	583	34
35	Emergency				22,596	375	5	34	32	15	88	35
36	Private Ambulatory											36
37	TOTAL	$	$	$	$1,774,466	$ 28,941	$ 4,472	$ 3,083	$ 2,941	$ 4,816	$ 7,757	37

FORM SSA-1562 (10-60)

PROVIDER NO. 00-0000

PERIOD: 7/1/66 - 12/31/66

Worksheet B
Second Apportionment

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2thru 19, Lines 21-37) (To Sched. C)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a													1a
1b													1b
2													2
3													3
4													4
5													5
6													6
7													7
8	$ 3,416												8
9		$ 475											9
10	328		$ 909										10
11			6	$ 2,976									11
12			509	301	$ 3,064								12
13			8		34	$ 179							13
14			11				$ 133						14
15			28		34			$ 265					15
16			3	30					$ 110				16
17			28	1,052	144					$ 1,842			17
18			59	1,533							$ 2,216		18
19												$ 7,286	19
20												22,438	20
21			59		242	22	16			195	417	233,863	21
22			8		104	17	7			172	303	76,642	22
23			3				18					20,014	23
24			45		116		5					121,435	24
25			79		138		3					142,303	25
26			3		25							15,824	26
27													27
28			57	60	67	9						105,979	28
29													29
30													30
32	3,076	475			1,612	115	68	217	110	1,247	1,467	831,842	32
33	12				159	6	6	3		140	29	67,373	33
34					340	1	4	37		79		106,238	34
35			3		49	9	6	8		9		23,229	35
36													36
37	$ 3,416	$ 475	$ 909	$ 2,976	$ 3,064	$ 179	$ 133	$ 265	$ 110	$ 1,842	$ 2,216	$1,774,466	37

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING Square Footage	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers	213,150	414,043		1,511,958	1,079,999	213,150	213,150	647,100	213,150	
1a	Provision for Depreciation: Bldg. & Fixtures										1a
1b	Provision for Depreciation: Movable Equip.										1b
2	Administration and General	14,493	23,185			100,444	14,493	14,493	2,592	14,493	2
3	Employee Health and Welfare	1,493	1,237		103,169	20,524	1,493	1,493	648	1,493	3
4	Operation of Plant	2,557	7,871		45,031	9,722	2,557	2,557	1,296	2,557	4
5	Maintenance of Plant	1,281	6,623		47,229	23,762	1,281	1,281	5,820	1,281	5
6	Laundry and Linen Service	5,755	6,207		38,538	23,762	5,755	5,755	1,296	5,755	6
7	Housekeeping	429	5,802		74,720	63,722	429	429	1,296	429	7
8	Dietary—Raw Food										8
9	—Other	6,042	8,010		68,731	18,954	6,042	6,042	4,956	6,042	9
10	Cafeteria	7,385	9,789		84,005	23,165	7,385	7,385	6,048	7,385	10
11	Maintenance of Personnel	38,794	5,802		11,237	3,238	38,794	38,794	18,768	38,794	11
12	Nursing Service	2,346	5,386		476,746	438,481	2,346	2,346	5,172	2,346	12
13	Medical Supplies and Expense	1,281	10,355		18,123	7,564	1,281	1,281	1,296	1,281	13
14	Pharmacy	1,064	5,802		56,563	8,643	1,064	1,064	648	1,064	14
15	Medical Records	1,281	5,386		25,379	22,683	1,281	1,281	648	1,281	15
16	Social Service	641	2,485		3,758	3,238	641	641	1,944	641	16
17	Nursing School	5,967	24,017		27,315	24,841	5,967	5,967	9,060	5,967	17
18	Intern-Resident Service	4,262	2,901		51,096	49,682	4,262	4,262	11,004	4,262	18
19	Organized Research	212			5,442	4,317	212	212	648	212	19
20	Fund Raising Activs.	636	3,722		16,855	12,951	636	636	1,296	636	20
	Special Service Cost Centers										
21	Operating Rooms	10,018	74,526		88,009	52,920	10,018	10,018	141,057	10,018	21
22	Delivery Rooms	4,262	8,276		11,969	6,476	4,262	4,262	40,115	4,262	22
23	Anesthesia		5,386		7,961	2,159			4,524		23
24	X-Ray	4,691	20,285		66,845	37,801	4,691	4,691	11,652	4,691	24
25	Laboratory	5,544	10,356		76,217	68,039	5,544	5,544	2,592	5,544	25
26	Blood Bank	852	4,970		7,494	3,238	852	852	648	852	26
27	Oxygen Therapy										27
28	Physical Therapy	2,769	9,108		62,254	48,594	2,769	2,769	16,824	2,769	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients	66,290	128,351		24,247		66,290	66,290	300,245	66,290	32
33	Nursery	6,608	3,306		7,269		6,608	6,608	42,707	6,608	33
	Outpatient Cost Centers										
34	Outpatients	14,068	4,554		3,183		14,068	14,068	10,356	14,068	34
35	Emergency	2,129	10,345		2,573	1,079	2,129	2,129	1,944	2,129	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$ 42,257	$ 35,823	$	$ 262,508	$ 121,081	$ 53,939	$ 58,417	$ 50,926	$ 95,164	37
38	Unit Cost Multiplier	.198250	.086520		.173621	.112112	.253057	.274065	.078699	.446465	38

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*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Worksheet B-1
First Apportionment

LINE NO.	DIETARY RAW FOOD (Meals Served)	DIETARY OTHER (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
	1,143,475	1,143,475	91,467	99	413,263	18,071	53,387	100	7,046	88,982	61,175	
1a												1a
1b												1b
2			3,765									2
3			664									3
4			443									4
5			1,560									5
6			1,993									6
7			7,973									7
8			3,544									8
9												9
10	109,851											10
11			433									11
12			40,089	10								12
13			664		4,546							13
14			886									14
15			2,214		4,546							15
16			221	1								16
17			2,214	35	19,423							17
18			4,651	51								18
19												19
20												20
21			4,651		32,648	2,259	6,460			9,432	11,501	21
22			664		14,051	1,699	2,883			8,276	8,381	22
23			221				7,314					23
24			3,544		15,704		1,976					24
25			6,202		18,597		1,121					25
26			221		3,306							26
27												27
28			4,429	2	9,092	922						28
29												29
30												30
32	1,029,716	1,143,475			217,377	11,583	27,280	82	7,046	60,240	40,498	32
33	3,908				21,489	596	2,189	1		6,763	795	33
34					45,872	54	1,708	14		3,826		34
35			221		6,612	958	2,456	3		445		35
36												36
37	$ 57,928	$ 63,812	$ 81,740	$ 53,194	$ 652,563	$ 31,237	$ 69,234	$ 42,781	$ 6,283	$ 92,822	$ 102,112	37
38	.050660	.055805	.89366	537.313131	1.579050	1.728571	1.296833	427.81	.891712	1.043155	1.669178	38

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING Square Footage	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers				1,745,525	959,031	194,607	193,326	635,448	187,142	
1a	Provision for Depreciation: Bldg. & Fixtures										1a
1b	Provision for Depreciation: Movable Equip.										1b
2	Administration and General				1,745,525						2
3	Employee Health and Welfare				4,399	959,031					3
4	Operation of Plant				2,988	9,722	194,607				4
5	Maintenance of Plant				2,764	23,762	1,281	193,326			5
6	Laundry and Linen Service				4,452	23,762	5,755	5,755	635,448		6
7	Housekeeping				7,315	63,722	429	429	1,296	187,142	7
8	Dietary–Raw Food				3,167	42,119					8
9	–Other						6,042	6,042	4,956	6,042	9
10	Cafeteria						7,385	7,385	6,048	7,385	10
11	Maintenance of Personnel					3,238	38,794	38,794	18,768	38,794	11
12	Nursing Service					438,481	2,346	2,346	5,172	2,346	12
13	Medical Supplies and Expense					7,564	1,281	1,281	1,296	1,281	13
14	Pharmacy					8,643	1,064	1,064	648	1,064	14
15	Medical Records					22,683	1,281	1,281	648	1,281	15
16	Social Service					3,238	641	641	1,944	641	16
17	Nursing School					24,841	5,967	5,967	9,060	5,967	17
18	Intern-Resident Service					49,682	4,262	4,262	11,004	4,262	18
19	Organized Research				7,128	4,317	212	212	648	212	19
20	Fund Raising Activities				21,957	12,951	636	636	1,296	636	20
	Special Service Cost Centers										
21	Operating Rooms				227,104	52,920	10,018	10,018	141,057	10,018	21
22	Delivery Rooms				74,158	6,476	4,262	4,262	40,115	4,262	22
23	Anesthesia				19,624	2,159			4,524		23
24	X-Ray				118,698	37,801	4,691	4,691	11,652	4,691	24
25	Laboratory				139,039	68,039	5,544	5,544	2,592	5,544	25
26	Blood Bank				15,458	3,238	852	852	648	852	26
27	Oxygen Therapy										27
28	Physical Therapy				103,515	48,594	2,769	2,769	16,824	2,769	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients				803,057		66,290	66,290	300,245	66,290	32
33	Nursery				65,134		6,608	6,608	42,707	6,608	33
	Outpatient Cost Centers										
34	Outpatients				102,972		14,068	14,068	10,356	14,068	34
35	Emergency				22,596	1,079	2,129	2,129	1,944	2,129	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$	$	$	$ 28,941	$ 4,472	$ 3,083	$ 2,941	$ 4,816	$ 7,757	37
38	Unit Cost Multiplier				.016580	.004663	.015842	.015213	.007579	.041449	38

FORM SSA-1562 (6-66)

*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

PERIOD 7/1/66 - 12/31/66

Worksheet B-1
Second Apportionment

LINE NO.	DIETARY RAW FOOD (Meals Served)	DIETARY OTHER (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
	1,143,475	1,143,475	89,422	99	413,263	18,071	53,387	100	7,046	88,982	61,175	
1a												1a
1b												1b
2												2
3												3
4												4
5												5
6												6
7												7
8	1,143,475											8
9		1,143,475										9
10	109,851		89,422									10
11			554	99								11
12			50,111	10	413,263							12
13			831		4,546	18,071						13
14			1,107				53,387					14
15			2,768		4,546			100				15
16			277	1					7,046			16
17			2,768	35	19,423					88,982		17
18			5,813	51							61,175	18
19												19
20												20
21			5,813		32,648	2,259	6,460			9,432	11,501	21
22			831		14,051	1,699	2,883			8,276	8,381	22
23			277				7,314					23
24			4,430		15,704		1,976					24
25			7,752		18,597		1,121					25
26			277		3,306							26
27												27
28			5,536	2	9,092	922						28
29												29
30												30
32	1,029,716	1,143,475			217,377	11,583	27,280	82	7,046	60,240	40,498	32
33	3,908				21,489	596	2,189	1		6,763	795	33
34					45,872	54	1,708	14		3,826		34
35			277		6,612	958	2,456	3		445		35
36												36
37	$ 3,416	$ 475	$ 909	$ 2,976	$ 3,064	$ 179	$ 133	$ 265	$ 110	$ 1,842	$ 2,216	37
38	.002987	.000415	.01016	30.060606	.007414	.009905	.002491	2.650000	.015612	.020700	.036224	38

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS) PERIOD: 7/1/66 to 12/31/66 PROVIDER NO. 00-0000 EXHIBIT III

CLASSIFICATION AND ADJUSTMENT OF HOSPITAL OPERATING EXPENSES (Omit Cents)

EXPENSE CLASSIFICATION	EXPENSES PER BOOKS	ADJUSTMENTS *Increases and (Decreases) (See page 2a)*	ADJUSTED OPERATING EXPENSES	INPATIENT EXPENSES	OUTPATIENT EXPENSES
	1	2	3	4	5
1. Administration and General	$ 328,389	$ (2,782)	$ 325,607	$	$
2. Dietary	172,356	(18,149)(5,673)	148,534	148,534	
3. Housekeeping	74,133		74,133		
4. Laundry	36,860		36,860		
5. Linen Service					
6. Maintenance of Personnel	4,681	(1,637)	3,044		
7. Operation of Plant	90,245		90,245		
8. Motor Service					
9. Repairs and Maintenance					
10. Nursing Service	475,815		475,815		
11. Nursing Education	29,482	(5,428)	24,054		
12. Medical & Surgical Service					
13. Interns, Residents, & Physicians		50,000	50,000		
14. Other Services and Supplies	69,359	(52,386)	16,973		
15. Pharmacy	55,850		55,850	51,940	3,910
16. Medical Records and Library	25,956	(1,297)	24,659		
17. Social Service	3,416		3,416	3,416	
18. Operating Rooms	79,575		79,575	73,607	5,968
19. Delivery Rooms	10,408		10,408	10,408	
20. Anesthesiology	7,495		7,495	6,933	562
21. X-ray	88,768	(24,608)	64,160	57,098	7,062
22. Laboratory	100,599	(26,377)	74,222	68,655	5,567
23. Basal Metabolism					
24. Electrocardiology					
25. Physical Therapy	60,917		60,917	56,348	4,569
26. Ambulance	5,907		5,907	5,907	
27. Inhalation Therapy					
28. Occupational Therapy					
29. Electroencephalography					
30. Blood Bank		6,895	6,895	6,895	
31. Postoperative Recovery Room					
32. Central Sterile Supply					
33. Outpatient Services					
34. Provision for Depreciation	78,080		78,080		
35. Interest Expense					
36. Rent of Land and Buildings					
37. Property Taxes					
38. Fund Raising Expenses					
39. Research (Organized)	5,400		5,400	5,400	
40. Nursery (Food)		5,673	5,673	5,673	
41. Fund Raising Activities	10,500		10,500	10,500	
42. Emergency	1,256		1,256		1,256
43. Subtotal	1,815,447	(75,769)	1,739,678	511,314	28,894
44. Indirect Costs Distributed*				1,135,310	64,160
45.					
46.					
47. Amt. not eligible for reim.		(33,288)	(33,288)	(33,288)	
48. Total	$ 1,815,447	$ (109,057)	$1,706,390	$1,613,336	$ 93,054
49. 2% allowance in lieu of specific recognition of other costs (A)			34,128	32,267	1,861
50. TOTALS			$1,740,518	$1,645,603	$ 94,915

FORM SSA-1564 (9-66) (A) Show computation on Form SSA-1563A 1a

* Sum of lines 1,3,4,6,7,10,11,13,14,16, and 34. See computation #2 Exhibit III-2.

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS) EXHIBIT III - 1

PROVIDER NO. 00-0000

PERIOD 7/1/66 to 12/31/66

ADJUSTMENTS TO EXPENSES (Omit Cents)

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT*	AMOUNT	EXPENSE CLASSIFICATION ON PAGE 1A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin. & Gen.	1
2.	Radio and television service	B	(594)	Admin. & Gen.	1
3.	Laundry and Linen Service				4 & 5
4.	Vending Machines Commission				7
5.	Employee and guest meals	B	(18,149)	Dietary	2
6.	Sale of drugs to other than patients				15
7.	Sale of medical and surgical supplies to other than patients				14
8.	Sale of medical records and abstracts	B	(1,297)	Medical Records	16
9.	Sale of scrap, waste, etc.	B	(1,484)	Admin. & Gen.	1
10.	Rental of quarters to employees and others	B	(1,637)	Maint. of Personnel	6
11.	Rental of hospital space				7
12.	Payments received from specialists				1
13.	Trade, quantity, time, and other discounts on purchases	B	(2,386)	Med.Supplies & Expenses	14
14.	Rebates and refunds of expenses				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				35
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	Nursing School	11
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	22 Various
21.	Fund raising expenses				Various
22.	Depreciation				34
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	TOTAL		$ (75,769)		

FORM SSA-1564 (9-66) *BASIS FOR ADJUSTMENT: A – Cost B – Amount Received

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS)

EXHIBIT III - 2

Provider No. 00-0000

Period

7/1/66 - 12/31/66

CALCULATION FOR GENERAL SERVICE COSTS
APPLICABLE TO NONALLOWABLE COST CENTERS

COMPUTATION #1

Subtotaled Costs (Line 43, Col. 3)		$1,739,678
Less: Overhead accounts included in the total - Exhibit III	(A)	600,000
Base for computation of rate	(B)	$1,139,678

Computation of Rate $\frac{(A)}{(B)}$ = $\frac{\$\ 600,000}{\$1,139,678}$ = 52.646%

Nonreimbursable Costs:	
Organized Research	$ 5,400
Fund Raising Activities	10,500
Ambulance	5,907
Total	$21,807
$21,807 times 52.646% =	11,481
Amount not eligible for reimbursement	$33,288

CALCULATION FOR ALLOCATING INDIRECT COSTS

COMPUTATION #2

Amount (Line 43, Col. 3)		$1,739,678
Less:		
Inpatient Expenses (Line 43, Col. 4)	$511,314	
Outpatient Expenses (Line 43, Col. 5)	28,894	540,208
Amount to be distributed		$1,199,470

Distribution:

	Direct Costs	Percent to Total	Indirect Costs Distributed
Inpatient Expenses	$511,314	94.651%	$1,135,310
Outpatient Expenses	28,894	5.349	64,160
	$540,208	100.000%	$1,199,470

NATIONAL LEAGUE FOR NURSING - METHOD I

EXHIBIT IV

PROVIDER NO. 00-7000

TOTAL OPERATING COSTS

SCHEDULE A-3

PERIOD ENDING YE 6/30/67

	HOME HEALTH AGENCY COST FROM RECORDS A	ADJUSTMENT TO COSTS (See Schedule A-3a) B	HOME HEALTH AGENCY ADJUSTED COSTS NET (Col. A & Col. B) C
1. SALARY COSTS (Salaries plus agency costs for retirement, social security, health insurance, other employee benefits.)			
(a) Director and administrative assistant	$ 7,000	$	
(b) Consultants	--		
(c) Supervisors	--		
(d) Professional nurses providing generalized services	29,400		
(e) Specialists – PT, OT, ST	6,950		
(f) Practical nurses	9,600		
(g) Home Health Aides	7,645		
(h) Clerical staff	8,105		
(i) Other (Specify)	--		$ 68,700
2. TRANSPORTATION COSTS			
(a) Automobile operating costs	$ 1,956	$	
(b) Automobile insurance	2,100	(200)	
(c) Automobile depreciation (Furnish details)	1,350		
(d) Gains or Losses on sale or disposition of automobiles	--		
(e) Other (Specify) (Public Transportation)	24		
(f) Automobile allowances paid to staff members	950		6,180
3. SERVICES PURCHASED FROM OTHER AGENCIES OR UNDER ARRANGEMENTS. (Contract Services)	-- $	$	--
4. MEDICAL AND NURSING SUPPLIES (Including non depreciable equipment)	$ 840	$ (206)	634
5. SPACE OCCUPANCY COSTS			
(a) Rent	$ 3,900	$	
(b) Heat and light	790		
(c) Maintenance and repairs	923	(800)	
(d) Taxes	--		
(e) Depreciation if building owned or donated (Furnish details)	--		
(f) Other (Specify)	--		4,813
6. OFFICE COSTS			
(a) Stationery and Printing	$ 440	$	
(b) Telephone and telegraph	875		
(c) Postage and express	180		
(d) Other (Specify) (Office Equipment Rental)	200		1,695
7. OTHER GENERAL COSTS			
(a) Depreciation on furniture and equipment (Furnish details)	$ 240	$ 120	
(b) Dues and subscriptions	25		
(c) Legal and accounting fees	100		
(d) Laundry	--		
(e) Inservice and Staff Education	--		
(f) Insurance (Other than automobile)	440		
(g) Cost of rental equipment furnished to patients (See instructions)	--		
(h) Other (Specify) (Sundry)	42		967
8. COST FOR SPACE OCCUPANCY, OFFICE AND OTHER GENERAL COSTS, FRINGE BENEFITS, ETC. NOT IDENTIFIABLE AND NOT INCLUDED IN ITEMS 1 THRU 7	$ --	$ --	--
9. SUBTOTAL ITEMS 1–8	$ 84,075	$ (1,086)	$ 82,989
10. ADD ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS (2% non profit) (1½% proprietary) OF LINE 9 COL. (c)			1,660
11. INTEREST	$ 142	$	142
12. RETURN ON EQUITY CAPITAL (Proprietary providers only)	$ --	$	--
13. TOTAL COSTS (Items 9 to 12)			$ 84,791

FORM SSA-1728 (7-67)

Rev. 4

EXHIBIT IV - 1
PROVIDER NO. 00-7000

ADJUSTMENTS TO EXPENSES (*Omit Cents*)

SCHEDULE A-3a
PERIOD ENDING
YE 6/30/67

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT*	AMOUNT	EXPENSE CLASSIFICATION ON PAGE 3, SCH. A-3, FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Trade, quantity, time and other discounts on purchases		$		
2.	Rebates and refunds of costs	B	(200)	Automobile Insurance	Various
3.	Amount applicable to Part B for physicians services				Various
4.	Fund raising costs				Various
5.	A "Meals on Wheels" program				
6.	Grants, gifts and income designated by the donor for specific expenses				Various
7.	Interest on unrestricted funds				
8.	Sale of medical and nursing supplies to other than patients	B	(206)	Medical and Nursing Supplies	
9.	Sale of drugs to patients				
10.	Capital items included in costs	A	(800)	Repairs and Maintenance	
11.	Tuition fee received				
12.	Depreciation *(Furnish Details)*		120	Depreciation on Furniture and Fixtures	
13.					
14.					
15.	TOTAL		$ (1,086)		

* Basis for adjustment
A—Cost B—Amount Received C—Estimate

FORM SSA-1728 (7-67)

EXHIBIT IV - 2

PROVIDER NO. 00-7000

COMPUTATION OF COST PER VISIT FOR AGENCY USING AVERAGE COST PER VISIT BASIS AND AVERAGE HOURLY COST FOR HOME HEALTH AIDES

SCHEDULE A-4

PERIOD ENDING YE 6/30/67

1.	Allowable costs from page, 3, Sch. A-3, Col. C. line 13	$ 84,791
2.	Less: Costs allocated to Home Health Aide visits *(Enter on line 7)*	11,487
3.	Net costs for visits *(Line 1, less line 2)*	$ 73,304
4.	Less: Deduction for non-visiting costs *(Sch. A-5)* Col. D., line 10	6,152
5.	Costs of visits, other than aides *(Enter on line 6)*	$ 67,152

6. Visit Costs $ 67,152 *(Other than aides)* ÷ Number of Visits* 8,490 *(Other than aides)* = Average Cost Per Visit $ 7.91 *(Include cents)*

7. Home Health Aide Costs $ 11,487 ÷ Number of Hours/Visits Home Health Aides 1,430 = Average Cost Per Hour/Visit $ 8.03 *(Include cents)*

* A visit is defined according to the definition listed in "Conditions of Participation for Home Health Agencies" publication HIM-2(3-66) U.S. Dept. of HEW, Social Security Administration. Do not include "Not home – not found," as a visit

DETERMINATION OF NON-VISITING COSTS

SCHEDULE A-5

Item A Time spent on staff level in non-visiting activities including related office and travel time. 940 hours ÷

Item B Total working time on staff level Minus time spent in community activity and staff education 11,750 hours =

Item C Percent not chargeable to the cost of making visits *(correct to first decimal)* 8.0 %

Item D Deduct 8.0 % for non-visiting costs. *(Apply percentage to Col. C costs where applicable and insert applicable amount in Col. D)*

	COSTS *(From Page 3 Sch. A-3, Col. C)*	TOTAL A	COSTS ALLOCATED FOR H.H. AIDES B	NET COSTS *(A minus B)* C	DEDUCTIONS D
1.	Salaries	$ 68,700	$ 9,799	$ 58,901	$ 4,712
2.	Transportation	6,180	360	5,820	465
3.	"Contract Services"	--			
4.	Medical and Nursing Supplies	634			
5.	Space Occupancy Costs	4,813	1,328	8,583	975
6.	Office Costs	1,695			
7.	Other General Costs	967			
8.	Costs Not Identifiable *(Not included in items 1-7)*	--			
9.	Misc. Costs – Includes items 10, 11, 12 of Schedule A-3	1,802			
10.	TOTAL	$ 84,791	$ 11,487	$ 73,304	$ 6,152
		Agrees with page 3, sch. A-3 Col. C, line 13	*Enter on line 2 sch. A-4 above*	*Agrees with line 3 sch. A-4 above*	*Enter on line 4 sch. A-4 above*

FORM SSA-1728 (7-67)

325-263 O - 68 - 5

SCHEDULE A-4 - HOME HEALTH AIDE COSTS

Total salaries	$68,700		
Less salary of director and clerical	15,105		
	$53,595		
Home Health Aides Salary	$ 7,645		
Percentage	14.26%		
Home Health Aide Costs --			
Salaries			$ 7,645
Transportation			360
Portion of indirect costs --			
Total Cost		$84,791	
Less-Direct Salaries	$53,595		
Transportation	6,180		
Rent Expense Applicable to Nonvisiting Activities	600	60,375	
		$24,416	
Percentage shown above		14.26%	3,482
			$11,487

SCHEDULE A-5 - TOTAL WORKING TIME ON STAFF LEVEL

Number of nurses on staff	6
Number of days worked by each nurse	250
Total nurse days in year	1,500
Total staff hours in year (1500 x 8)	12,000
Less time spent on staff education and community activities	250
	11,750

SCHEDULE A-5 - COMPUTATION OF NONVISITING COSTS FOR LINES 3 TO 9

Total of lines 3 to 9, column C		$8,583
Less space occupancy rent applicable to		
Visiting activities	$3,300	
Non-visiting activities	600	3,900
		$4,683
% nonvisiting costs		8%
		$ 375
Add rent for nonvisiting activities		600
Total of lines 3 to 9, column D		$ 975

EXHIBIT IV - 6

PROVIDER NO. 00-7000

CALCULATION OF REIMBURSABLE COST OF HOME HEALTH SERVICES

SCHEDULE A-1

PERIOD ENDING YE 6-30-67

LINE NO.	TYPE OF VISITS	AVERAGE COST PER VISIT (Include cents)	POST HOSPITAL PLAN PART A		MEDICAL PLAN PART B	
			NO. OF VISITS	COSTS (Omit cents)	NO. OF VISITS	COSTS (Omit cents)
1.	All Visits Combined	$ 7.91	360	$ 2,848	1,050	$ 8,306
2.	Skilled Nursing Care					
3.	Physical Therapy					
4.	Speech Therapy					
5.	Occupational Therapy					
6.	Medical Social Services					
7.	Other Covered Visits (Specify)					
8.	Home Health Aide — NUMBER OF HOURS: PART A / PART B	UNIT COST: per visit $ 8.03			350	2,811
9.	Cost of Rental Equipment					
10.	TOTAL COST INCURRED (Items 1 thru 9) OR TOTAL COST (Sch. A-9 line 8)			$ 2,848		$ 11,117
11.	Less: Deductibles chargeable to Health Insurance Program Patients					900
12.	Net Cost (Line 10 less line 11)			$ 2,848		$ 10,217
13.	80% of Net Cost (Line 12, part B) applicable to Health Insurance Program					$ 8,174
14.	Less payments made or to be made by intermediary/SSA for period (Exclude current financing)			2,160		6,000
15.	Balance due Home Health Agency/Intermediary exclusive of bad debts			688		$ 2,174
16.	Total reimbursable bad debts (Schedule A-2 line 10)					300
17.	Total amount due Home Health Agency/Health Insurance Program (Sum of lines 15 and 16)			$ 688		$ 2,474

REIMBURSABLE BAD DEBTS (Applicable to Part B only)

SCHEDULE A-2

1.	Total Home Health costs applicable to Part B of Health Insurance Program (Schedule A-1, Line 10, Part B)	$ 11,117
2.	Less amount received or to be received from Intermediary or Social Security Administration (Schedule A-1, Line 14 plus Line 15)	8,174
3.	Balance to be recovered from HI Program home health patients (Line 1 minus line 2)	$ 2,943
4.	Deductibles and coinsurance billed to HI Program home health patients	$ 2,400
5.	Less: Bad debts for deductibles and coinsurance	300
6.	Net deductibles and coinsurance billed to HI Program home health patients	$ 2,100
7.	Unrecovered from HI Program patients (Line 3 less line 6). If line 6 is greater than line 3 enter zero on lines 7 and 8. (Complete line 7 only when line 3 exceeds line 6.)	$ 843
8.	Reimbursable bad debts—current period—lower of line 5 or line 7	$ 300
9.	Add or subtract bad debts NET of recoveries for prior periods reported	- 0 -
10.	Total reimbursable bad debts (Sum of lines 8 and 9) (Enter on schedule A-1 line 16)	$ 300

FORM SSA-1728 (7-67)

PROVIDER NO. 00-7000

CALCULATION OF REIMBURSABLE COST OF HOSPITAL BASED HOME HEALTH SERVICES BASED ON RCCAC APPORTIONMENT

SCHEDULE A-1

PERIOD YE 6-30-67

	RATIO OF CHARGES TO CHARGES APPLIED TO COST *(Omit Cents)*	POST HOSPITAL PLAN *(Part A)*	MEDICAL PLAN *(Part B)*
1.	Total amount of home health charges *(gross)* all patients *(Use same amount in both columns)*	$ 58,440	$ 58,440
2.	Total amount of patient charges *(gross)* Health Insurance Program	$ 2,160	$ 8,400
3.	Percent Health Insurance Program charges to total gross charges *(Line 2 divided by line 1 rounded to the first decimal place)*	3.7 %	14.4 %
4.	Total cost of home health services *(From Form SSA-1562, Schedules B) (Use same amount in both columns)*	$ 84,791	$ 84,791
5.	Less: Cost of non-covered services for which no charge is made on line 1 above per schedule A-3 page 3 – Line 10. *(Use same amount in both columns)*	6,152	6,152
6.	Total cost of home health services for which charges have been made *(Line 4 less line 5) (Use same amount in both columns)*	$ 78,639	$ 78,639
7.	Percent applicable to Health Insurance Program – *(Line 3 above)*	3.7 %	14.4 %
8.	Total cost applicable to Health Insurance Program *(Line 6 multiplied by line 7)*	$ 2,910	$ 11,324
9.	Less: Deductibles billed to Health Insurance patients		900
10.	Net Cost *(Line 8 less line 9)*	$ 2,910	$ 10,424
11.	80% of net cost *(Line 10)* applicable to Health Insurance Program		$ 8,339
12.	Less: Payments made or to be made by intermediary or SSA for the period *(Exclude current financing)*	$ 2,160	$ 6,000
13.	Balance due Home Health Agency/Health Insurance Program exclusive of bad debts *(Part A line 10 less line 12) (Part B – Line 11 less line 12)*	$ 750	$ 2,339
14.	Total reimbursable bad debts *(Schedule A-2 line 10)*		$ 300
15.	Total amount due Home Health Agency/Health Insurance Program for Part A and Part B services *(Line 13 plus line 14)*	$ 750	$ 2,639

REIMBURSABLE BAD DEBTS (Applicable to Part B only)

SCHEDULE A-2

1.	Total home health costs applicable to part B of Health Insurance Program *(Line 8–Part-B–Schedule A-1)*	$ 11,324
2.	Less: Amount received or to be received from Intermediary or Social Security Administration *(Line 12 plus line 13–Schedule A-1)*	8,339
3.	Balance to be recovered from HI Program home health patients	$ 2,985
4.	Deductibles and coinsurance billed to HI Program Home Health Patients	$ 2,400
5.	Less: Uncollectible deductibles and coinsurance amounts	300
6.	Net deductibles and coinsurance billed to HI Program Home Health Patients *(Line 4 less line 5)*	$ 2,100
7.	Unrecovered from HI Program Patients *(Line 3 less Line 6)* If line 6 is greater than line 3 enter zero on lines 7 and 8; *(If line 3 is greater than line 6, enter the difference here)*	$ 885
8.	Reimbursable bad debts for current period – lesser of line 5 or line 7	$ 300
9.	Add or subtract reimbursable bad debts net of recoveries for prior periods reported	- 0 -
10.	Total Reimbursable Bad Debts *(Sum of lines 8 and 9) (Enter on Schedule A-1 Line 14)*	$ 300

FORM SSA-1729 (7-67)

EXHIBIT V - 1

PROVIDER NO. 00-7000

COMPUTATION OF AVERAGE COST PER VISIT BASED ON COST CENTER-STAFF NURSING ONLY

SCHEDULE A-6

PERIOD ENDING YE 6/30/67

COMPUTATION OF COST PER VISIT FOR YEAR

	TYPE OF EXPENSE	NUMBER OF HOURS		COST PER HOUR	COST		
		VISITING	ALL OTHER SERVICE		VISITING	ALL OTHER SERVICE	TOTAL
1.	SALARY FOR DIRECT SERVICE Staff Nurse	10,810	940	$ 3.25	$ 35,132	$ 3,055	$ 38,187
2.	Supervisor						
3.	Physical Therapist	900	100	6.95	6,255	695	6,950
4.	Home Health Aide	4,000	--	1.91	7,645	--	7,645
5.	Contracted Services						
6.							
7.	Cost of supervision						
8.	Cost of consultation service						
9.	Cost of transportation				6,180	--	6,180
10.	Direct allocations of expense				3,300	600	3,900
11.	Overhead cost				17,527	1,524	19,051
	12. Sum of above factors				76,039	5,874	81,913
	13. Pro rata share of staff education and community activities				1,133	85	1,218
	14. Allowance in lieu of specific recognition of other costs				1,544	116	1,660
	15. Total Cost				$ 78,716	$ 6,075	$ 84,791
	16. Number of Visits				9,920		Per EXHIBIT IV
	17. Cost per Visit *(Line 15 divided by line 16)* Enter on Sch. A-1 or Complete Sch. A-7 for each discipline				$ 7.94		

COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Skilled Nursing		SCHEDULE A-7
1.	1.487 (A) hours of Staff nurse @ $3.25 (B) per hour	$ 4.833
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $5280 ÷ 7,270 visits	.726
5.	Overhead cost of 1.487 hours @ $ 1.115 (C) per hour	1.658
5A	Direct Allocation (Rent) ($3300 ÷ 9920 visits)	.333
	Subtotal	7.550
6.	Pro Rata share of costs of staff education and participation in community activities @ $.0149 per dollar ($1218 ÷ $81,913)	.113
	Subtotal	7.663
7.	Allowance in lieu of specific recognition of other costs (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $7.663	.153
8.	TOTAL COST PER VISIT	$ 7.816

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

(A) $\frac{10,810 \text{ hrs}}{7,270 \text{ visits}} = 1.487 \text{ hours}$

(B) $\frac{\$39,000}{12,000 \text{ hours}} = \$3.25$

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hrs.

(C) $\frac{\$17,527 \text{ overhead costs}}{15,710 \text{ hrs.}} = \$1.115$ per hour

COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Physical Therapy		SCHEDULE A-7
1.	.738 (A) hours of Staff nurse @ $ 6.95 (B) per hour	$ 5.129
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $540 ÷ 1220 visits	.443
5.	Overhead cost of .738 hours @ $ 1.115 (C) per hour	.823
5A	Direct allocation (Rent) ($3300 ÷ 9920 visits)	.333
6.	Pro Rata share of costs of staff education and participation in Subtotal	6.728
	community activities @ $.0149 per dollar $1218 ÷ 81913	.100
7.	Allowance in lieu of specific recognition of other costs Subtotal (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $6.828	6.828 .137
8.	TOTAL COST PER VISIT	$ 6.965

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

(A) $\frac{900 \text{ hours}}{1,220 \text{ visits}} = .738 \text{ hours}$

(B) $\frac{\$6,950}{1,000 \text{ hours}} = \$6.95$

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hours

(C) $\frac{\$17,527 \text{ overhead costs}}{15,710 \text{ hours}} = \$1.115$ per hour

NATIONAL LEAGUE FOR NURSING - METHOD II

EXHIBIT V-4

COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Home Health Aides		SCHEDULE A-7
1.	2.797 (A) hours of Staff nurse @ $ 1.90 per hour	$ 5.314
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $360 ÷ 1430 visits	.252
5.	Overhead cost of 2.797 hours @ $ 1.115 (C) per hour	3.119
5A	Direct Allocation (Rent) ($3300 ÷ 9,920 visits)	.333
6.	Pro Rata share of costs of staff education and participation in Subtotal	9.018
	community activities @ $.0149 per dollar $1218 ÷ 81,913	.134
7.	Subtotal Allowance in lieu of specific recognition of other costs (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $9.152	9.152 .183
8.	TOTAL COST PER VISIT	$ 9.335

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

FORM SSA-1728 (7-67)

(A) $\frac{4000 \text{ hours}}{1430 \text{ visits}}$ = 2.797 hours

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hours

(B) $\frac{\$7,645}{4,000 \text{ hours}}$ = $1.90 per hour

(C) $\frac{\$17,527 \text{ overhead cost}}{15,710 \text{ hours}}$ = $1.115 per hour

SCHEDULE A-7, SUMMARY OF SKILLED NURSING, PHYSICAL THERAPY, AND HOME HEALTH AIDES

Skilled nursing	$7.929 x 7,270 VTS. =	$57,644
Physical therapy	$7.942 x 1,220 VTS. =	9,689
Home health aides	$7.936 x 1,430 VTS. =	11,348
Total		$78,681
Rounding differences		35
Total per Schedule A-6, line 15		$78,716

EXHIBIT VI

PROVIDER NO. 00-7000

ALLOCATION OF OPERATING COSTS AND CALCULATION OF COST PER VISITS

SCHEDULE A-8

PERIOD ENDING YE 6/30/67

	CLASSIFICATION OF COSTS	TOTAL AGENCY COSTS (Omit cents)	UNIDENTIFIED TO SPECIFIC DISCIPLINE	COSTS IDENTIFIABLE TO SPECIFIC DISCIPLINE OR PROGRAM AREA						
				SKILLED NURSING CARE	PHYSICAL THERAPY	SPEECH THERAPY	OCCUPATIONAL THERAPY	MEDICAL SOCIAL SERVICES	HOME HEALTH AIDES	OTHER (Specify)
		A	B	C	D	E	F	G	H	I
1.	Salaries	$ 53,595	$	$ 39,000	$ 6,950	$	$	$	$ 7,645	$
2.	Transportation Costs	6,180	--	5,280	540				360	
3.	Contracted Services	--	--							
4.	Medical and Nursing Supplies	634	634							
5.	Space Occupancy Costs	4,813	4,813							
6.	Office Costs	1,695	1,695							
7.	Other General Expense Costs	967	967							
8.	Other costs not included in Items 1–7 Sch. A-3, Item 8	--	--							
9.	Misc. Costs Sch. A-3 Items 10, 11, 12	1,802	1,802							
10.	Total Costs (excluding salaries) sum of lines 2–9	$ 16,091	$ 9,911	$ 5,280	$ 540	$	$	$	$ 360	$
11.	Amount of unidentified costs to be charged to each discipline. Apply ratio in Line 11 Col. B to Line 1 on each column.	To calculate percent divide Col. B Line 10 by Col. A Line 1.	.1849 %	7,212	1,285				1,414	
12.	**Administrative Salaries to be Allocated** / Salaries of all other personnel to be allocated	$ 15,105 / $ 53,595	.2818 % Apply ratio to Line 1 of each column	10,991	1,959				2,155	
13.	**Total Costs for each discipline** *(Sum of Items 1, 10, 11 and 12)*			$ 62,483	$ 10,734	$	$	$	$ 11,574	$
14.	Percent of Time spent during Reporting Period			92.0 %	90.0 %	%	%	%	100.0 %	%
15.	Home Visits – Disease or Disability *(Multiply line 13 by line 14)*			$ 57,484	$ 9,661	$	$	$	$ 11,574	$
16.	Number of Home Visits – Disease or Disability Made during Reporting Period			7,270	1,220				1,430	
17.	Cost of Home Visits – Disease or Disability *(Divide line 15 by line 16 – Transfer Result to A-1, Lines 2-8)*			$ 7.91	$ 7.92	$	$	$	$ 8.09	$

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EXHIBIT VII

PROVIDER NO. 00-7000

CALCULATION OF HI PROGRAM COST OF HOME HEALTH SERVICES BASED ON RCCAC APPORTIONMENT

SCHEDULE A-9

PERIOD ENDING YE 6/30/67

RATIO OF CHARGES TO CHARGES APPLIED TO COST *(Omit Cents)*	POST HOSPITAL PLAN *(Part A)*	MEDICAL PLAN *(Part B)*
1. Total amount of home health charges *(gross)* all patients *(Use same amount in both columns)*	$ 58,440	$ 58,440
2. Total amount of patient charges *(gross)* Health Insurance Program	$ 2,160(1)	$ 8,400(2)
3. Percent Health Insurance Program charges to total gross charges *(Line 2 divided by line 1)* rounded to first decimal place	3.7 %	14.4
4. Total cost of home health services *(Schedule A-3)* *(Use same amount in both columns)*	$ 84,791	$ 84,791
5. Less: Cost of non-covered services for which no charge is made on line 1 above per schedule A-10, Line 10 *(Use same amount in both columns)*	6,152	6,152
6. Total cost of home health services for which charges have been made *(Line 4 less line 5)* *(Use same amount in both columns)*	$ 78,639	$ 78,639
7. Percent applicable to Health Insurance Program – *(Line 3 above)*	3.7 %	14.4 %
8. Total cost applicable to Health Insurance Program *(Line 6 multiplied by line 7)* transfer to Sch. A-1, Line 10	$ 2,910	$ 11,324

Per EXHIBIT IV

(1) 360 visits @ $6.00 = $2,160

(2) 1,050 visits @ $6.00 = $6,300
350 visits for 3 hrs.
@ $2.00 per hour = 2,100
$8,400

COST ADJUSTMENTS FOR NON-COVERED HOME HEALTH SERVICES

(To be used with Schedule A-9)

SCHEDULE A-10

(Include also costs of services for which no charge is made)

DESCRIPTION	AMOUNT
1. Clinics, classes, etc.	$ 6,152
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10. Total Cost of Non-Covered Services *(Sum of Lines 1 through 9)* *(Enter on Line 5, Schedule A-9)*	$ 6,152

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EXHIBIT VIII

PROVIDER NO. 00-7000

COST ADJUSTMENTS FOR NON-COVERED HOSPITAL-BASED HOME HEALTH SERVICES

SCHEDULE A-3

PERIOD: YE 6/30/67

(Include also costs of services for which no charge is made)

DESCRIPTION	AMOUNT	
1. Clinics, classes, etc.	$ 6,152	
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10. Total Cost of Non-Covered Services *(Sum of Lines 1 through 9)* *(Enter on Line 5–Schedule A-1)*	6,152	$

HOME HEALTH SERVICES DIRECT EXPENSE ANALYSIS

SCHEDULE A-4

ITEMIZE DIRECT HOME HEALTH COSTS	AMOUNT	
1. SALARY COSTS	$	
(a) Administrative Staff	15,105	
(b) Consultants		
(c) Professional Nurses	39,000	
(d) Interns/Residents		
(e) Other *(Specify)* Physical Therapist	6,950	
(f) Home Health Aides	7,645	
(g)		
(h)		
(i)		$ 68,700
2. CONTRACT SERVICES		
(a) Visiting Nurse Association	$	
(b) Equipment Rentals	200	
(c) Other *(Specify)*		
(d) Building rental for clinics, classes, etc.	600	
(e)		
(f)		800
3. MEDICAL SUPPLIES AND EXPENSES *(Specify)*	$ 634	
(a)		
(b)		634
4. TRANSPORTATION COSTS *(Specify)*		
(a) Operating costs and insurance	$ 3,856	
(b) Travel allowances and public transportation	974	4,830
5. OTHER DIRECT EXPENSES *(Specify)*	$	
(a) Legal and accounting	100	
(b)		
(c)		
(d)		
(e)		100
6. Total Direct Home Health Expenses *(Sum of lines 1(a) through 5(e))* *(Line 6 should agree with Home Health Cost Center – Column 1, Form 1562, Worksheet B)*		$ 75,064

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Chapter 24

PAYMENTS TO PROVIDERS

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Chapter 24

PAYMENTS TO PROVIDERS

2400. PRINCIPLE

Providers of services will be paid the reasonable cost of services furnished to beneficiaries. Interim payments approximating the actual costs of the provider will be made at least monthly or more frequently on the most expeditious basis administratively feasible. A retroactive adjustment based on actual costs will be made after the end of the reporting period. At the request of the provider, payment will be made on a basis designed to reimburse currently for services rendered to beneficiaries.

2402. DEFINITIONS

2402.1 Providers of Services.—Providers of services means hospitals, extended care facilities, and home health agencies. After June 30, 1968, these will also include clinics, rehabilitation agencies, and public health agencies which provide physical therapy services.

2402.2 Participating Providers.—A participating provider is an approved provider of service which has entered into an agreement with the Department of Health, Education, and Welfare to (a) accept payment based on the reasonable cost of the items and services furnished; (b) not to charge the beneficiary or any other person for covered items and services, except deductibles and coinsurance amounts; and (c) to return any money incorrectly collected.

2402.3 Hospital for Emergency Services.—An emergency hospital is a nonparticipating hospital which has not entered into an agreement with the Department of Health, Education, and Welfare to participate in the program but may receive payment for covered services, in accordance with § 2416.2, after complying with the appropriate statutory requirements and regulations.

2402.4 Federal Providers of Service.—A Federal provider of service may enter into an agreement as a provider only if the Secretary determines that it is providing services to the public generally as a community institution or agency. Payment will be made in accordance with § 2418.

2404. PAYMENTS TO PARTICIPATING PROVIDERS

A participating provider will be paid, at least monthly, for the cost of covered services rendered Medicare beneficiaries. These payments will be based on an interim rate that shall approximate actual costs as nearly as is practicable.

Upon receipt of a cost report for the provider's Medicare reporting period, the intermediary will make a tentative retroactive adjustment. This adjustment will be based on the cost report as submitted, subject to the initial review by the intermediary. Final settlement will be made after an audit of the provider's records, and an agreement is made between the provider and the intermediary as to the total allowable cost due the provider.

In addition to interim payments, providers may request 'current financing" (see § 2410) and "accelerated payments" (see § 2412).

2406. INTERIM RATES

An interim rate for covered inpatient services may be expressed either as a percentage of the charges made for such services or as a per diem amount based on the allowable costs of these services.

Prior to January 1, 1968, the interim rate for covered outpatient services was expressed as a percentage of charges, an amount per visit, or an amount per occasion of service. On and after January 1, 1968, the outpatient interim rate must be expressed as a percentage of charges.

2406.1 Interim Rate—Initial Reporting Period.—When a provider first participates in the program an interim rate of payment may be established on any of the following bases:

1. The provider may be receiving reimbursement from the intermediary or other third party payor on a cost or cost-related basis. The rate established for this purpose may be used, adjusted to the allowable cost under the program.
2. Where no organization is paying the provider on a cost or cost-related basis, the initial interim rate may be determined from the previous year's cost and statistical data, illustrated as follows:

 A. Operating expenses for most recent year ---------- $_____

B. Add or Deduct: Adjustment of expenses (See Schedule A-5, Form SSA-1562 for examples) _____ ———
C. Add or Deduct: Projected increases or decreases in allowable expenses ———
D. Add:
Allowance in lieu of recognition of other costs
2% (non-profit institutions) or
1½% (proprietary institutions) ———
Return on Equity Capital _____ ———
E. Total estimated allowable expenses $═══

Calculation of Interim Reimbursement

	In-patient	*Out-patient*	*Total*
F. (a) Projected total patient revenue	$	$	$
(b) Percentage	%	%	%
G. Total estimated allowable cost—Line E × Line F(b)	$	$	$
H. Patient days		NA	NA
I. Interim rate expresed as:			
Per diem (Line G ÷ Line H)	$	NA	NA
Percentage (Line G ÷ Line F)	%	%	%

2406.2 Interim Rate for New Providers.—The intermediary will use one of the following methods to determine an appropriate interim rate for newly established providers which do not have cost experience on which to base an interim rate of payment:

1. Use the interim rate established for a provider which is comparable in substantially all relevant factors to the new provider.
2. Determine an interim rate based on the budgeted or projected costs in the same manner as illustrated in § 2406.1.

After determining an interim rate the intermediary will review the provider's cost experience after a period of 90 days in the program, and make appropriate adjustment if required.

2406.3 Adjustment of Interim Rate.—An interim rate of payment may be adjusted at any time during an accounting period. Such adjustment may be made: (a) upon request of the provider supported by a schedule showing that actual costs incurred to date plus estimated costs to be incurred will be signigcantly higher or lower than the computed one, or (b) if there is evidence available to the intermediary that actual costs will be significantly higher or lower than the computed rate.

2406.4 Retroactive Lump-Sum Interim Payment.—A retroactive lump-sum interim payment may be made when a provider has been significantly underpaid in the current reporting period. The need for such retroactive payment will generally result from an incorrect determination in the initial rate, or through increases in cost, e.g., salary and wage increases, which are applicable retroactively.

2406.5 Interim Rates After Initial Reporting Period.—Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering health insurance services. Upon the submission of appropriate evidence, the costs of the prior period should be adjusted to reflect any anticipated increase or decrease in costs for the current period.

2407. PERIODIC INTERIM PAYMENT METHOD OF REIMBURSEMENT (PIP)

The periodic interim payment (PIP) reimbursement method for hospital inpatient services is available to all types of participating hospitals meeting these requirements: (1) total Medicare payment for inpatient service computed under the new method is at least $25,000 on an annual basis, (2) the hospital has filed with its intermediary at least one completed cost report under the Medicare program, and (3) the intermediary is assured that the hospital has the continuing capability of maintaining in its records the cost, charge and statistical data needed to accurately complete a Medicare cost report on a timely basis. Any hospital that establishes to the satisfaction of the intermediary that it meets these requirements has the option to request the intermediary to make payments under this method.

When a hospital first enters the program and requests the intermediary to make payments under this method, the intermediary may waive the cost reporting requirement (requirement 2) where the hospital establishes to the satisfaction of the intermediary that it can comply with requirements 1 and 3.

2407.1 Payment Interval.—Payments are made on a weekly basis unless the hospital, at its option,

requests the intermediary to make payments at fixed intervals of more than one week but not less often than monthly. These payments will approximate the cost of the average level of Medicare inpatient services rendered by the hospital during the payment interval. Weekly payments are recommended in order to avoid placing any financial burden on hospitals by providing funds as nearly as possible after the time of providing services.

2407.2 Computation of Periodic Interim Payment—Hospital with Experience under the Program.—The intermediary is responsible for determining the amount of the periodic interim payment. Before making payment under the PIP method, the intermediary computes the amount per inpatient day which reflects the hospital's anticipated costs of providing covered services (1) during the forthcoming reporting period where payments under the new method are effective with the beginning of the hospital's reporting year, or (2) during the current reporting period where the intermediary approves the hospital's election to be paid under the new method subsequent to the beginning of its reporting year. Where an intermediary is currently making interim payments on a per diem basis, a projection from the current rate is appropriate.

Hospitals which received prior interim payments on a percentage of charge basis will have such percentage converted to an equivalent amount per inpatient day. Intermediaries will also compute a per diem deductible amount representing the deductible and coinsurance amounts. The difference between the cost per inpatient day and deductible and coinsurance amount per inpatient represents the program responsibility on a per inpatient day basis and will be used in computing the periodic interim payment amount.

The formula for this computation is as follows:

$$\frac{(C - B) \times D}{PI} = PIP$$

C = cost per inpatient day
B = beneficiary deductible and coinsurance amount per inpatient day
D = projected annual Medicare days
PI = payment interval factor

Beneficiary responsibility for deductible and coinsurance amounts remains the same and these amounts should be charged and collected by the hospital from the beneficiary.

Example A

Hospital A is currently being reimbursed at the rate of $37 per day. Based on the hospital's most recent HS&R report it is determined that beneficiary deductible and coinsurance amount per inpatient day is $3 (Item 8 Inpatient Deductible + Item 9 Inpatient Coinsurance ÷ Item 13 Accommodation Days). The hospital anticipates a 10 percent increase in cost and estimates 4,000 Medicare days for the reporting period. Using the above formula:

$$\frac{(\$37 + 10\% \text{ of } \$37 - \$3) \times 4{,}000 \text{ days}}{52} = PIP$$

$$\frac{\$150{,}800}{52} = \$2{,}900$$

Of course, where the hospital requests payment on a bi-weekly or semi-monthly basis the divisor would be 26 or 24, respectively.

2407.3 Computation of Periodic Interim Payments—New Hospitals.—The intermediary will use the following methods to determine the appropriate PIP payment when a hospital first enters the program and no cost experience is available:

1. Where there is a hospital or hospitals for which payments have been established and which are comparable in substantially all relevant factors to the new hospital, the intermediary will base the payments to the new hospital on the costs and Medicare utilization of the comparable hospital.
2. If there are no substantially comparable hospitals from which data are available, the intermediary will determine a payment based on budgeted or projected costs of the new hospital and estimated Medicare utilization of services.

2407.4 Computation of Periodic Interim Payment—Alternative Method Reflecting Seasonal Variation in Utilization of Services.—A hospital may request that its periodic interim payment reflect variations in utilization when its inpatient Medicare experience shows a significant seasonal variation in utilization of services. Recognition of such variations in utilization is limited to a quarterly basis starting with the beginning of a hospital's reporting year. Quarterly periods must correspond with the required quarterly recomputation periods as explained in § 2407.5.

Example B

Assume all of the facts presented in Example A. In addition the hospital's reporting year under Medicare is the calendar year and its records for calendar

year 1967 show Medicare inpatient utilization as follows: January 1-March 31, 1967—35%, April 1-June 30, 1967—25%, July 1-September 30, 1967—15%, October 1-December 31, 1967—25%. Accordingly, weekly payments during 1968 could be computed as follows:

$$\text{1st Quarter PIP} = \frac{35\% \times \$150{,}800}{13} = \$4{,}060$$

$$\text{2nd Quarter PIP} = \frac{25\% \times \$150{,}800}{13} = \$2{,}900$$

$$\text{3rd Quarter PIP} = \frac{15\% \times \$150{,}800}{13} = \$1{,}740$$

$$\text{4th Quarter PIP} = \frac{25\% \times \$150{,}800}{13} = \$2{,}900$$

Where a hospital requests PIP payments reflecting variations in utilization, its payments for the entire provider reporting year will be computed by the intermediary on this basis. However, the hospital may annually elect to receive payments for each reporting year on a straight line basis or on the basis reflecting variations in utilization where experience shows significant quarterly seasonal variations.

2407.5 Recomputation Following Submission of Cost Report.—The intermediary will recompute the periodic interim payment immediately after it has completed a desk review of the hospital's annual cost report for the preceding reporting period. The recomputed payment will be adjusted for such factors as would appropriately reflect the hospital's estimated cost of providing covered services to beneficiaries for the year following the period covered by the cost report. A projection will also be made by the intermediary of the deductible and coinsurance amounts which are the responsibility of the beneficiary and other appropriate corresponding adjustment factors applied in arriving at the hospital's estimated Medicare costs, as well as the bad debt experience of the hospital. The formula for this computation is as follows:

$$\frac{MC - DC}{PI} = PIP$$

MC = estimated Medicare cost

DC = estimated beneficiary deductible and coinsurance payments

PI = payment interval

Example C

Hospital C which receives interim payments on a weekly basis submits its cost report for the preceding accounting year. After cost finding and apportionment in accordance with the Principles of Reimbursement for Provider Costs, it is determined that the cost of 2,000 Medicare inpatient days was $100,000. For the ensuing year, the hospital estimates a 20% increase in Medicare utilization and a 10% increase in costs. In addition, the deductible and coinsurance data in the example contained in the above narrative apply. Converting the aggregate Medicare cost to an average cost per diem (for interim payment purposes only) a cost per inpatient day of $50 ($100,000 ÷ 2,000 days) is determined. Based on a realistic projection for the ensuing year, a cost of $55 per day ($50 + 10% increase) and utilization of 2400 days (2,000 + 20% increase), an estimated annual Medicare cost of $132,000 is computed. Using the above formula:

$$\frac{(\$55 \times 2400 \text{ days}) - (\$3.25 \times 2400 \text{ days less } 2\% \text{ bad debts})}{52 \text{ weeks}} = PIP$$

$$\frac{\$132{,}000 - \$7{,}644}{52} = \$2{,}391$$

2407.6 Alternative Computation of Deductible and Coinsurance Factor (DC) of Formula.—An acceptable alternative in projecting the DC factor in the formula would be the deductible and coinsurance payments paid by beneficiaries for the prior period adjusted upward or downward to reflect the appropriate rate of the deductible ($40 in 1968) per admission where a realistic change in Medicare utilization is projected. For example, assume the deductible and coinsurance amounts collected from beneficiaries in the prior years was $7500 and the hospital anticipated a 5% increase in Medicare utilization, that is, from 2,000 Medicare days to 2,100 Medicare days. On the basis of the average length of stay for the aged in the formula would be $7,500 plus $320. (The $320 represents 100 additional Medicare days ÷ 14 days

average length of stay for the aged in this hospital × $40 or 8 × $40. The conversion of days to admissions should be rounded to the next highest number.)

2407.7 Other Recomputations of Periodic Interim Payment.—The hospital may at any time request and be allowed an appropriate prospective increase in the periodic interim payment amount upon presentation of significant evidence to the intermediary that costs or Medicare utilization has increased. Likewise, the intermediary may at anytime adjust the periodic interim payment if it has evidence that the hospital's actual costs or Medicare utilization has fallen significantly below the computed rate. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submission to the intermediary of completed admission and billing forms.

The intermediary is required to recompute the periodic interim payment not less frequently than quarterly. In addition, upon completion of the desk review of the completed Medicare cost report, the intermediary will make a recomputation without regard to the time interval elapsed since the immediately preceding recomputation. The intermediary will then resume its established schedule of recomputations. The overall objective of the intermediary surveillance of the periodic interim payments is to assure payments approximating actual costs as closely as possible.

2407.8 Lump-Sum Interim Payments.—As with other methods of interim reimbursement, the intermediary may make a lump sum payment to the hospital to bring past interim payments in line with costs where it has been advised that the hospital has incurred significant expenditures not otherwise reflected in the periodic interim payment.

2407.9 Offset of Outstanding Accelerated Payments.—Accelerated payments are not needed by any hospital receiving payments under the PIP method. The intermediary will commence to offset accelerated payments against bills submitted for prior period services and for which an accelerated payment had been made. It is expected that the offset will be fully accomplished simultaneously with the conclusion of payment based on individual bills covering services provided before the beginning of the reporting period for which the periodic interim payment method is put into effect.

2407.10 Repayment of Current Financing Payment.—Current financing payments will no longer be required by hospitals which implement this method. Therefore, outstanding current financing payment must be repaid. Repayment may be made by a payment from the hospital to the intermediary or on the basis of a reasonable schedule of reductions from the succeeding periodic interim payments. Repayment of the outstanding current financing must be within 18 months following the receipt by the hospital of its first periodic interim payment.

2407.11 Status Verification Procedure.—The intermediary will establish a formal inpatient admission follow-up procedure for each hospital receiving payments under the periodic interim payment method. This means that the hospital will be contacted by its intermediary on a regular scheduled basis, but not less than monthly, regarding any open admission that is more than 30 days old as of the status verification date. The hospital is expected to respond to the intermediary within a reasonable time.

2408. RETROACTIVE ADJUSTMENTS

A retroactive adjustment will be made after the end of the provider's reporting year to bring the interim payment made during the period into agreement with the reimbursable amount payable to the provider. This adjustment will be determined, from the respective settlement sheets applicable to the cost reporting form and apportionment method used by the provider. The adjustment, using the hospital form, is illustrated below:

Tentative Retroactive Adjustment Based on Form SSA–1563—Calculation of Reimbursement Settlement

Line		
17.	Totals (either column 5, Departmental Method or column 6, Combination Method)	$1,000,000
18.	Deductibles and coinsurance billed to Health Insurance Program patients	$ 10,000
19.	Subtract: Bad debts for deductibles and coinsurance	1,000
20.	Net deductibles and coinsurance billed to Health Insurance Program patients	$ 9,000

21.	Amount received or receivable from intermediary or SSA (excluding current financing)[1,2]	$ 965,000
22.	Plus: Accommodation differential[3]	500
23.	Total amount received or billed for covered services (line 20 plus line 21 plus line 22)	$ 974,500
24.	Balance due hospital/Health Insurance Program (line 17 minus line 23)	$ 25,500

2408.1 Computation of Amount Received or Receivable from Intermediary.—After the first reporting period, this amount is computed as illustrated below:

Computation of Line 21, Page 2, Form 1563
For Hospitals Who Are Filing A Second Year Report

1.	Bills submitted to Part A Intermediary for services (to HI inpatients) through the end of current year for which payment has not been received as of year end	$_____
2.	Less: Part B charges included above—if any. (e.g., ambulance services, certain ancillary services, etc.)	_____
3.	Sub-total	$_____
4.	Interim payment percentage	_____%
5.	Estimated cost for services to HI patients (line 3 × line 4)	$_____
6.	Less: Deductibles and coinsurance	_____
7.	Net estimated amount to be received from intermediary	$_____
8.	Actual amount received from intermediary during year	_____
9.	Total of line 7 and 8	$_____
10.	Less: "Estimated amount to be received" used in previous year cost report	_____
11.	Amount to be used in line 21	$_____

Similar computations would be made where interim reimbursement is on a per diem basis by substituting days and per diem interim rates in the above format.

[1] This amount may be taken from the Provider Statistical and Reimbursement Report, adjusted for interim payments receivable; the provider's records; or records which the intermediary has been authorized to maintain.
[2] If retroactive lump-sum payments have been made during the year, those amounts should be included if the Provider Statistical and Reimbursement Report is used (see § 2408.2).
[3] See § 2208.4 for example of Accommodation Differential calculations.

2408.2 Tentative Retroactive Adjustment.—In order to reimburse the provider as quickly as possible, a tentative adjustment will be made as soon as the cost report is received and reviewed by the intermediary. For this purpose, the costs will be accepted as reported (unless there are obvious errors or inconsistencies) subject to later audit.

2408.3 Data Used in Determining the Tentative Retroactive Adjustment.—Tentative retroactive adjustments will be based on the data which the intermediary determines will result in the most accurate reimbursement to the provider. This data may be obtained from the provider's own records, the Provider Statistical and Reimbursement Report, or records which the intermediary has been authorized to maintain. The intermediary is authorized to pay the full amount of the tentative retroactive adjustment on the basis of the data determined to be the more accurate even though the amount of the adjustment varies widely with that which would be obtained from other data, such as the Provider Statistical and Reimbursement Report. Retroactive lump-sum interim payments are not currently included in the Provider Statistical and Reimbursement Reports. These payments should be added to the total reimbursement shown on the Provider Statistical and Reimbursement Report when determining the amount of the tentative retroactive adjustment. In the future the Provider and Statistical Reimbursement Report will show these lump-sum payments.

2408.4 Final Retroactive Adjustment.—A final retroactive adjustment will be made by the intermediary after an audit of the provider's cost report and an agreement is made between the intermediary and the provider as to total allowable cost.

2408.5 Overpayment to Providers.—Cost reports submitted by providers, showing balances due the program must be accompanied by the provider's remittance for such balance due. If a lump-sum payment is not practical, the intermediary and provider may arrange for recovery of any overpayment by means of deductions from future interim payments. Usually, full recovery should be made wtihin 90 days after the filing of the cost report, unless the particular circumstances dictate otherwise.

2410. CURRENT FINANCING PAYMENTS

In addition to the basic procedure for payment to a provider following the submission of bills to the intermediary, payment will be made upon request by the provider on a basis designed to reimburse currently for services furnished to beneficiaries.

2410.1 Responsibility of the Intermediary.—The maximum amount of the current financing payment allowable will be computed quarterly by the intermediary based upon data derived from the provider's and intermediary's records based on the provider's most current experience under the program. The intermediary must be assured that the data used are the most accurate currently available.

2410.2 Time for Requesting Payment.—Providers may at any time request current financing payments and furnish such basic data as is required by the intermediary in order to determine the maximum payment. However, the intermediary may not disburse a current financing payment until after the provider's first month under the program. Such payment may not exceed the maximum amount determined under the formulae presented below, utilizing data from the records of the provider and intermediary.

2410.3 Formulae for Providers.

1. *Statistical and financial data required for hospitals and extended care facilities which generally bill the intermediary at or after date of discharge of beneficiaries:*

 (a) One-half average length of stay of aged in the particular institution.

 The intermediary will use actual length of stay data based on the billings it has received from the provider and paid under the program. (Where these data are not available and until they become available, these data will be estimated by the intermediary on the basis of the data obtained from comparable institutions.)

 (c) Calendar days equivalent to the average of the actual time required by provider to prepare inpatient bills but not to exceed 7 days.

 The intermediary will estimate this billing time on the basis of an adequate sample of the most recent inpatient bills available to the intermediary, based on the date of discharge (or the date the intermediary assumes the provider started to prepare his bills) and the date such bills were mailed to the intermediary. If the intermediary is unable to establish this estimate, it should obtain from the provider a statement of the provider's estimate of its billing time, supported by appropriate back-up data for the estimate.

 (p) Calendar days equivalent to the average time required for the intermediary to process the billings including transit time of billing from provider to intermediary and transit time of remittance from intermediary to provider.

 (q) Calendar days represented by period for which interim payments were disbursed, during the key month of program experience, generally July and October, 1966, January, April, July, and October 1967, and similar months in subsequent years. This key month could, for the initial computation, be any other month representing the provider's first full month of experience under the program; for example, for a provider which enters the program on February 1, 1967, the key month would be its experience in the month of February.

 (r) Total interim payments to the provider for all covered provider services (inpatient and outpatient—the latter under both Parts A and B of the program) disbursed by the Intermediary during the key month of program experience.

Computation Formula

$$(a + c + p) \times \frac{r}{q} = X \text{ (amount of current financing payment)}$$

Note: The sum of (a + c + p) cannot exceed 30 days. If the sum does exceed 30 days, use 30 days in the computation.

In determining the average length of stay and bill preparation and processing time, days will be expressed as whole days with a fractional part of a day to be counted as a whole day. For example, the average length of stay is 14½ days—this will be shown as 15 days; the provider's billing process takes 3½ days—this will be counted as 4 full days.

2. *Statistical and Financial data for all providers which generally bill the intermediary at regular intervals without regard to the date of discharge of beneficiaries.*

 The formula and computations are the same except for factor "a" (a) One-half the number of days in the regular billing period arranged by the particular institution with the intermediary for services to beneficiaries.

Example—Provider A
Statistical and financial data

(a) One-half the number of days in the regular biweekly billing period 14 days ÷ 2 = 7.

(c) Average of actual time for provider to prepare inpatient bills = 3 days.

(p) Intermediary processing time including transit time 8 days (6 + 2).

(q) Days represented by period for which interim payments were disbursed by intermediary during January 1967—30 (twice each month on the 15th and 30th).

(r) Total interim payments disbursed by intermediary during January 1967—$30,000.

Computation Formula

$$(a + c + p) \times \frac{r}{q} = x$$

$$(7 + 3 + 8) \times \frac{\$30{,}000}{30}$$

18 × $1,000 = $18,000 (Amount of Current Financing Payment)

2410.4 Initial Current Financing Payments.—Where provider billing or intermediary processing for the first month of the provider's operations under the program is not normal—the flow of Medicare billings and payments for the first month may not have reached a normal rate due to various factors such as new procedures, new forms, new relationships between the provider and the intermediary—the initial current financing payment may be computed by using the following data for the formulae described in § 2410.3.

1. Actual data for the first month's operations,
2. Estimated data (established by the intermediary) for the first month's operations showing an amount which the intermediary would have disbursed to the provider if during the first month in question the system of provider billing and intermediary processing were functioning normally, or
3. Actual data for the first two month's operations—in this case, the payment may be disbursed only after the second month under the program.

The latest or most current data should always be used, especially for those providers which have not requested a current financing payment but have been in the program a sufficient length of time for the normal computation or recomputation.

2410.5 Periodic Recomputation of Current Financing Payment.—Where an intermediary has made a current financing payment it must make a quarterly recomputation of that payment each February, May, August, and November based on the provider's average operating experience for the three months of the preceding calendar quarter and the first month of the current quarter, or the operating experience of the first month of the current quarter, or the operating experience of the first month in the current quarter in which the recomputation takes place, whichever provides the higher base. This recomputation must be made in accordance with the appropriate formula.

2410.6 Recomputation Greater than Existing Payment.—Where the recomputation shows that the allowable payment is greater than the present current financing payment, the provider may request additional funds to bring the present payment up to the level of the recomputed payment.

2410.7 Recomputation Less than Existing Payment.—Where a quarterly recomputation shows that the allowable payment is less than the amount previously paid, the difference need not be repaid unless two consecutive quarterly recomputations show that the allowable amount is less than the outstanding current financing payment. Where two consecutive recomputations both show that the allowable amount is less than the amount previously paid, the amount by which the existing payment is greater than the allowable amount of the second recomputation must be repaid. For example, the provider has been previously paid $50,000. The first recomputation shows an allowable amount of $45,000 and the second recomputation shows an amount of $48,000. The amount which must be repaid would be $2,000 ($50,000 — $48,000). This excess amount must be repaid in a lump-sum by the provider to the intermediary or by a reduction in the next interim payment(s) to the provider, or a combination of the two. In every instance, such amount must be fully paid before the next scheduled recomputation by the intermediary.

2410.8 Effect of "Accelerated Payments" on Current Financing Payments.—Factor (r) in the Formula for computing current financing payments is equal to the total interim payments for all covered services which were disbursed by the intermediary during the month on which the recomputation is based. Where an intermediary has disbursed an accelerated payment (see § 2412) to a provider during the month on which the recomputation is based, the amount of the accelerated payment should not be included in factor (r). The intermediary may use as factor (r) an amount which it estimates would have been disbursed to the provider if during the month the system of provider billing and intermediary processing were functioning normally. Where interim payments were offset by the recoupment of accelerated payments, the determination of the total payments made during that base month should exclude the recoupment deductions.

2412. ACCELERATED PAYMENTS

A provider may be eligible to request accelerated payments in instances where delays in the receipt of funds for covered services rendered to beneficiaries would cause financial difficulties for the provider. The amount of the accelerated payment will be computed as a percentage of the amount of net reimbursement represented by unbilled discharges or unpaid bills applicable to covered services rendered to beneficiaries. A provider that has a current financing payment (see § 2410.) may also request an accelerated payment. Accelerated payments must be approved by the intermediary and the Social Security Administration.

2412.1 Eligibility for Payment.—Provider eligibility for accelerated payments will be contingent on information furnished the intermediary by the provider which demonstrates the existence of all of the following conditions:

(1) A shortage of cash exists whereby the provider cannot meet current financial obligations,

(2) The cash balance is seriously impaired due to abnormal delay in claims processing and/or payment by the intermediary, or delay in the billing process by the provider.
The provider must also demonstrate that the delays in its billing process are being corrected and are not chronic;

(3) The provider's cash position would not be alleviated by receipts anticipated to be received shortly; and

(4) The financial difficulty is not due to a lag in its billing to and/or payments by persons other than beneficiaries of this program.

2412.2 SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCELERATED PAYMENT

1. Provider: Provider No.:
 Address:
2. Intermediary:
3. Check (a) or (b) or both if applicable:
 Cash balance is seriously impaired due to:
 ☐ (a) Abnormal delay in Title XVIII claims processing and/or payment by the health insurance intermediary.
 ☐ (b) Delay in provider billing process. Delay is not of a chronic nature nor due to a lag in payment by other third party agencies.
4. a. General Fund Cash position of provider as of: _____ -------- $_____
 b. Anticipated receipts in next four weeks ---------- $_____
 c. Anticipated expenditures in next four weeks ---------- $_____
 d. Indicated cash position in next four weeks (a + b + c) ---------- $_____

2412.3 Computation of the Accelerated Payment.—To compute the accelerated payment on account:

1. Determine the amount of the interim reimbursement for unbilled and unpaid claims;
2. Subtract the deductibles and coinsurance amounts, and
3. Multiply by 70% to determine the net reimbursable amount which can be paid to the provider.

The following is illustrative of the accelerated payment computation:

a. Inpatient (hospital and extended care facility)

	Per Diem Basis	*Charges Basis*
Unbilled		
Number of discharges unbilled	40	40
Number of patient days represented	300	---
Amount of Charges	---	$20,000
Billed		
Number of bills not paid	50	50
Number of patient days represented	500	---
Amount of Charges	---	$20,000
Total	800	$40,000
Interim reimbursement rate	$ 45	90%
Interim amount due	$36,000	$36,000
Less deductible and coinsurance	12,000	12,000
Net reimbursement	$24,000	$24,000
Authorized	70%	70%
Inpatient accelerated payment requested (a)	$16,800	$16,800

b. Outpatient or Home Health

	Charges Basis
Unbilled	
Amount of charges	$10,000
Number of visits or occasions of service _____	

Billed

Amount of charges	15,000
Number of visits or occasions of service	
Total	$25,000
Interim reimbursement rate	90%
Interim amount due	$22,500
Less: deductibles and coinsurance	5,000
Net reimbursement	$17,500
Authorized rate	70%
Outpatient accelerated payment request (b)	$12,250
Total Accelerated Payment requested (a) and (b)	$29,050

2412.4 Recoupment of the Accelerated Payment.—An accelerated payment should be recouped within 90 days after it is made. Such recoupment may be effected by offsetting the outstanding amount against subsequent interim payments to the provider. In determining an equitable repayment arrangement the rate of recoupment should not be so rapid that it impairs the cast position that the accelerated payment was intended to improve, nor should it be delayed so that the provider, in effect, has an advance of funds. Ideally, the repayment should be effected at the same rate that reimbursement is made for unpaid bills and unbilled discharges represented in the computation.

2414. COST REPORTING PERIOD

For cost reporting purposes, the program will require submission of annual reports covering a 12-month period of operations based upon the provider's accounting year. At the option of the provider, however, during the first year of the program a short period report beginning July 1, 1966, and ending with the provider's accounting year may be submitted, provided such report covers at least 6 months.

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the intermediary approves a change in the provider's reporting period.

A cost reporting period under the program will consist of one of the following and will be considered in compliance with the reporting periods cited above.

1. 12 succesive calendar months,
2. 13 four-week periods with an additional day (two in a leap year) added to the last week or period to make it coincide with the end of the calendar year or month,
3. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.) and always end on (a) whatever date this same day of the week last occurs in a calendar month, or (b) whatever date this same day of the week falls which is nearest to the last day of the calendar month even though this same day falls in the first week of the following month. A new provider beginning operatons on January 1, 1967, and entering the program as of that date could choose a reporting period beginning with that date and ending, for example, Monday, December 25, 1967. This provider's accounting period would end on the same day of the week (Monday) and on whatever date that day of the week last occurs in the final month of the year. Alternatively, the provider could elect to end its first reporting period on January 1, 1968; this would be based on the election to end the period on the same day of the week which is nearest to the last day of the calendar year even though the last day falls in the first week of the following month. The method selected must be consistently followed.

2414.1 Short Period Reports.—A provider may be permitted to prepare a cost report for part of a year under the circumstances presented in § § 2414.2 through 2414.5.

2414.2 Providers Which Began Operations After the Start of the Program.—Upon entering the health insurance program, a new provider (one which started operations after the inception of the program) may select an initial cost reporting period of at least 1 month but not to exceed 13 months. For example, a new provider which starts with the Medicare program on September 15, 1966, and wishes to adopt a reporting period ending September 30, must file a report for the period September 15, 1966, to September 30, 1967. Such a provider cannot file a report for the 15-day period ending September 30, 1966.

2414.3 Providers in Operation at the Start of the Program.—A provider in operation and participating at the inception of the health insurance program (July 1, 1966, for hospitals and home health agencies and January 1, 1967, for extended care facilities) may file its first report for a period under the program of less than 12 months but not less

than 6 months. For example, a provider that files a 9-month cost report ending March 31, 1967, will be presumed to have selected an annual reporting year ending on March 31. Therefore, its second year report will cover the year beginning April 1, 1967, and ending March 31, 1968.

A provider having a reporting year that ends after June 30 but before December 31, 1966, cannot file a short period cost report. A facility in operation at the inception of the health insurance program (July 1, 1966, for hospitals and home health agencies, and January 1, 1967, for extended care facilities) which subsequently enters the program must file a cost report for 12 months if its initial reporting period covers less than 6 months under the program. For example, a facility which enters the program October 1, 1966, and selects a reporting period ending December 31, 1966, must file its first cost period for the period January 1, 1966, to December 31, 1966. Such a provider may not file a short period report covering the period October 1, 1966 to. December 31, 1966. Short period reports which are occasioned by changes in cost reporting periods as covered in § 2414.4 and § 2414.5 will be permitted.

2414.4 Termination of Participation in the Program.—When a provider voluntarily or involuntarily ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of termination of its provider agreement. Contingent upon the circumstances involved in the preparation of the cost report covering the effective date of termination of its provider agreement, the provider may file a cost report under the program for a period of not less than 1 month, and not more than 13 months.

2414.5 Changing of Cost Reporting Periods.—A provider must adhere to the cost reporting period initially selected unless a change has been authorized by its intermediary. The SSA should be notified promptly of such changes. Notification of the authorized changes must be received 90 days before the close of the reporting period to allow the Administration to adjust its records. Such a change may be made only after the intermediary has established that the reason is consistent wtih the purposes and intent of the program. Under the foregoing circumstance the provider may file a cost report for a period of not less than one month and not more than 13 months. A change which is made primarily to maximize reimbursement in any one period would not be acceptable.

Providers owned and/or operated by governmental entities using fiscal year ending dates established by local law, may require changes in the reporting year ending dates as a result of legislative action. In such situations, a provider with the approval of its intermediary may revise its cost reporting period to conform to the new fiscal year established by the applicable lawmaking body. A transitional period report covering the period initially affected by the change should be filed provided it covers a period of not less than one nor more than 13 months.

2416. PAYMENT TO NONPARTICIPATING PROVIDERS

Payments for emergency services can be made only if the claim for payment filed by the hospital is accompanied by a supporting statement by the physician who evaluates the Medicare patient's condition immediately upon arrival at the hospital, or by the physician who attended the patient at the place where the incident necessitating hospitalization occurred (e.g., in the case of a heart attack or an automobile accident):

a. describing the nature of the emergency;
b. furnishing relevant clinical information about the condition of the patient; and
c. certifying that the services rendered were necessary to prevent the death or serious impairment of the health of the individual.

2416.1 Procedure for Handling Claims.—Claims for payment for emergency services furnished by nonparticipating providers will be reviewed by the Social Security Administration Regional Office with professional assistance furnished by the Public Health Service. Payment of these claims under the principles stated below will be made by an intermediary designated by the Social Security Administration to handle emergency claims.

2416.2 Reimbursement Calculation—Nonparticipating Hospitals.—Under the 1965 law, payment could be made to a nonparticipating hospital for emergency services furnished to Medicare beneficiaries. However, such services could only be paid for if the institution met certain statutory requirements and billed the program for Medicare reimbursement. The law now provides, under a temporary provision applying to admissions to hospitals which occur before 1968, that reimbursement may be made to an individual who was furnished inpatient hospital services in certain nonparticipating hospitals, whether or not an emergency existed, subject to certain limitations

of coverage and rates of payment (see HIM–10, Hospital Manual, § § H202 and H208).

A. *Reimbursement to Hospitals Prior to January 1, 1968*—Payment on claims submitted by nonparticipating hospitals will be computed on the following basis:

(1) Inpatient Services:

(a) 90% of the hospital's most recent average per diem cost for all patients as calculated by a non-governmental third party payor (applied prospectively from the date such per diem cost was determined) or 85% of the hospital's regular charges for the services rendered to the beneficiary, whichever is lower,

(b) The cost of services rendered, as determined in (a) above, must be adjusted for any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

(2) Outpatient Services:

(a) 85% of the hospital's regular charges for the services rendered to the beneficiary which will represent the cost of such services.

(b) The amount as determined in (a) above must be adjusted for the applicable deductible. This resulting amount represents the basis for reimbursement by the program.

(c) The program will reimburse the hospital in an amount equal to 80% of the amount determined under (b). The beneficiary is responsible for 20% of the regular charges for these services.

Payment made pursuant to (1) and (2) above will be adjusted to an actual cost basis provided that complete financial and statistical reports are submitted in the same form and content required for participating hospitals (see Chapters 22 and 23) within 90 days following the close of the hospital's accounting period.

Each hospital which bills for emergency services will furnish the intermediary a copy of its regular charge schedule. This schedule need be submitted only once a year; however, any adjustments in the schedule should be submitted promptly.

B. *Reimbursement After December 31, 1967*—Hospitals can elect to bill the program and be reimbursed on an actual or estimated cost basis as outlined in "A" above. If this election is made, a cost report may also be filed to adjust payments made to an actual cost basis. For emergency outpatient services, furnished in nonparticipating hospitals, only diagnostic services are covered until April 1, 1968. After March 31, 1968, emergency outpatient services are covered as if furnished by a participating hospital, e.g., blood, nonself-administered drugs, etc. All these services are covered under Part B after March 31, 1968. Payment is on an actual or estimated cost basis. The payment is 80 percent of the actual or estimated cost less the applicable deductible to be met. The hospital may elect to bill Medicare patients and collect the charges. The Medicare patient will be reimbursed by the program in accordance with HIM–10, Hospital Manual. The hospital must, however, make the election for a complete calendar year and bill either the program or the Medicare patient.

2418. PAYMENTS TO FEDERAL PROVIDERS OF SERVICE

Claims for payment of emergency services furnished by Federal hospitals will be handled directly through the Social Security Administration in Baltimore, Maryland—Direct Reimbursement Branch, 8–K–8 Paca-Pratt Building.

Payment will be made to the appropriate parent Federal agency, rather than to the individual hospital. Reimbursement will be based on the inpatient and outpatient rates published by the Bureau of the Budget in the Federal Register of August 12, 1966, (Volume 31, Number 156), Page 10754.

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PROVIDER REIMBURSEMENT MANUAL

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM-15 (7-67)

FOREWORD

This manual is for use by providers of services in computing the reasonable cost of services furnished under the provisions of the Health Insurance for the Aged Act of 1965, as amended. The procedures and methods in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries. The manual contains informational and procedural material on various aspects of the determination of cost and will assist providers in preparing annual cost reports. This manual will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished. The provider's intermediary will issue any necessary supplementary instructions as appropriate for local guidance on items relating to cost determination.

The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations.

The manual will accommodate new pages or revisions as further interpretations of the regulations and changes in procedures and methods are made. Accordingly, revised sections, pages, or chapters will be issued as necessary.

Questions by a provider on cost policies and procedures in the program should be referred to the provider's intermediary. Providers dealing directly with the Social Security Administration may refer questions on cost determinations to the Bureau of Health Insurance Regional Representative.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance

NOTE: Chapter I, Depreciation, is the first of several chapters which will constitute the manual. Other chapters will be released as they become available.

INTRODUCTION

Regulations pertaining to the medicare program set forth principles to be followed in determining the reasonable cost of provider services. These "Principles of Reimbursement for Provider Costs" have also been published in HIM–5. This manual provides guidelines and policies to be followed in implementing the cost principles. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

Under generally accepted accounting principles, or under the "Principles of Reimbursement for Provider Costs" there may be more than one method for handling a particular cost item; in such case the method elected by the provider must be consistently followed in subsequent reporting periods. A change of method must be approved by the intermediary (or SSA for providers dealing direct) on a prospective and not retrospective basis. Where the manual sets a time limit for requesting such change, or limits the number of changes, the provider and intermediary will be guided by the manual instructions.

If a provider has any question on how to determine reasonable cost, or how to apply any part of this manual in a particular situation, it should submit the question to its intermediary (or to the Social Security Administration if it deals with the Government). Answers to questions raised by some providers which may be of interest to other providers will periodically be added to the applicable chapters and sections of this manual.

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Chapter I
DEPRECIATION

100. GENERAL

The principles of reimbursement for provider costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

Three methods of prorating the cost of depreciable assets are available: straight-line, declining balance, and sum-of-the-years' digits. The method chosen for the medicare program for an asset or groups of assets need not correspond to the methods used by the provider for nonmedicare purposes.

102. PRINCIPLES

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and (c) prorated over the estimated useful life of the asset using the straight-line method or accelerated depreciation under the declining balance or sum-of-the-years' digits methods.

Depreciation on assets being used by a provider at the time it enters into the Title XVIII program is allowed; this applies even though such assets may be fully or partially depreciated on the provider's books.

With respect to all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percent to be applied is 5 percent starting with the year 1966–67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to a regular depreciation on assets acquired after 1965; however, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired or rented after 1965 may not exceed 6 percent of the provider's allowable cost for the current year.

Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

104. DEFINITIONS

Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation. The amount of depreciation is determined by the provider's method of depreciation accounting.

The American Institute of Certified Public Accountants defines depreciation as a process of cost allocation:

> "Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

104.1 Depreciable Assets.—Assets that a provider has an economic interest in through ownership —regardless of the manner in which they were acquired—are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a provider is using under a regular lease arrangement would not be subject to depreciation by the provider. (See section on Lease-Purchase and Sale-Lease-Back Agreements (§ 110).)

In general, assets subject to depreciation are de-

scribed in the AHA Chart of Accounts for Hospitals, M–58, 15M—8/66—183305, and for the most part are also subject to depreciation for medicare purposes. However, see the treatment of minor equipment as described below.

104.2 Buildings.—Building includes, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

104.3 Building Equipment.—Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (a) affixed to the building, and not subject to transfer; and (b) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

104.4 Major Moveable Equipment. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, X-ray machines, etc. The general characteristics of this equipment are: (a) a relatively fixed location in the building; (b) capable of being moved as distinguished from building equipment; (c) a unit cost sufficient to justify ledger control; (d) sufficient size and identity to make control feasible by means of identification tags; and (e) a minimum life of approximately three years.

104.5 Minor Equipment.—Minor equipment includes such items as waste baskets, bed pans, syringes, catheters, silverware, mops, buckets, etc. The general characteristics of this equipment are: (a) in general, no fixed location and subject to use by various departments of the provider's facility; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and, (e) generally, a useful life of approximately three years or less.

104.6 Land (Non-depreciable).—Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacements is not the responsibility of the provider and other land expenditures of a non-depreciable nature.

104.7 Land Improvements (Depreciable).—Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).

104.8 Leasehold Improvements. — Leasehold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

104.9 Accounting Records.—The depreciation allowance, to be acceptable, must be adequately supported by the provider's accounting records. For medicare purposes, a provider may maintain supplementary records apart from formal records, but in a manner similar to that used in maintaining formal records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical costs (or fair market value at the time of donation in the case of donated assets), the method of depreciation, and the assets' accumulated depreciation.

104.10 Historical Cost.—Historical cost is the cost incurred by the present owner in acquiring the asset and to prepare it for use. Such cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees, related legal fees.

104.11 Historical Cost, Trade-Ins.—When an asset is acquired by trading in an asset that was depreciated under the program, the cost of the new asset would be the sum of the undepreciated balance of the old asset and the cash paid or to be paid. Where the old asset was acquired by the provider before entrance into the program, and the sum of the undepreciated balance and the cost paid or to be paid exceeds the list price, the cost of the new asset will be the list price.

For assets having no historical or appraisal values assigned, the cost basis shall be the fair market value at the date of disposal of the old asset plus the sum paid but not to exceed the list price.

104.12 Appraisals.—Where historical cost records of a purchased asset are not available an appraisal of the historical cost of the asset made by a recognized expert will be acceptable for depreciation and owner's equity capital purposes. Before an appraisal is made, the provider should inform its intermediary (or the Social Security Administration if the provider is dealing directly with the Government) of the appraisal expert, and the type and method of appraisal he will use. The intermediary (or SSA) will determine whether the contemplated appraisal for determining historical cost will be acceptable.

The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal expert making the appraisal should be one who is recognized as an appraisal authority based on sufficient experience and background in determining the historical cost of used assets.

104.13 Lease-Purchase Assets.—The historical cost of such assets is the sum of the lease payments and any additional payments made to acquire the assets, excluding the amount allowed as rent during the period of the lease or rental arrangement.

104.14 Purchase of Facility As An On-Going Operation.—In establishing the historical cost of assets where an on-going facility is purchased through a bona fide sale after June 30, 1966, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of sale. If the facility was being operated under the program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report, must agree with the historical cost used by the new provider in computing depreciation.

If a purchaser cannot demonstrate that the sale was bona fide, the lesser of the seller's net book value or sale price shall be used by the purchaser as the historical cost of the asset. In such cases, the difference between the sale price and the net book value shall be considered good will. The good will so established is not amortizable.

104.15 Fair Market Value—Donated Assets.—Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition. An asset is considered *donated* when the provider acquires the asset without making any payment for it in the form of cash, property, or services. When the provider makes any such payment in acquiring the asset, then this payment, and not the fair market value, is considered to be the historical cost of the asset.

104.16 Donated Assets — Appraisals.—Where the provider's records do not contain the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

The provider should furnish its intermediary (or the Social Security Administration if the provider deals directly with the Government) with information identifying the appraisal expert, and type and method of appraisal to be used. The intermediary (or SSA) will determine whether the contemplated appraisal will be acceptable.

104.17 Useful Life of Depreciable Assets.—The depreciable life of an asset is its expected useful life to the provider; not necessarily the inherent useful or physical life. The useful life is determined in the light of the provider's experience and the general nature of the asset and other pertinent data. Some factors for consideration are: (a) normal wear and tear, (b) obsolescence due to normal economic and technological advances, (c) climatic and other local conditions, (d) provider's policy for repairs and replacement, and (e) expected or known retirement date.

Providers may utilize the useful life guidelines published by the American Hospital Association or the Internal Revenue Service. A different life may be used; however, when the life selected differs significantly from that established by the guides, it must be supported by adequate documentation. Also, a composite useful life may be used for a class or group of assets.

104.18 Useful Life, Leasehold Improvements.—The cost of improvements which are the responsibility of the provider under the terms of a lease may be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter. The term of the lease includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the

provider or in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc.: unless the provider establishes omitting past acts, that it will probably not renew, extend, or continue the lease.

104.19 Salvage Value, Depreciable Assets.—Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and except for the declining balance method, is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for $17,000 with an expected salvage value of $2,000; the basis for depreciation becomes $15,000—i.e., $17,000 less $2,000—for computing the depreciation.

Thus, if a provider disposes of its assets when they are in good operating condition, the salvage value would be higher than it might if the provider used the assets until their inherent life had been substantially exhausted.

106. METHODS FOR WRITING OFF COST OF MINOR EQUIPMENT

The original cost of the minor equipment needed to operate the provider's facility may be treated in any of the following methods:

a. The original investment in this equipment is not amortized or depreciated. Any replacements are charged to operating expense. The investment in non-amortizable equipment is adjusted periodically by increases; or

b. The inventory cost of such items at the time the provider enters the program may be written off ratably over 3 years; that is, 1/3 of the inventory cost is written off each year. Any new purchases will also be written off ratably over a 3-year period; or

c. Certain categories of equipment such as, for example, surgical instruments, may be written off ratably over their actual useful lives.

108. CAPITALIZATION OF EXPENDITURES FOR DEPRECIABLE ASSETS

Realistic standards must be set by providers in establishing the cost and useful lives of depreciable assets purchased which will be capitalized. For example, the policy of a particular provider may be to capitalize all depreciable asset expenditures of $50.00 or more when the asset has an estimated useful life of three years or longer, while asset expenditures of less than $50 would be charged to expense. The standards so established must be followed consistently. Irrespective of the policy established, depreciable assets costing $100 or more must be capitalized. Where an asset is purchased in quantity so that the cost of the quantity exceeds $200 the cost of the individual items must be capitalized.

110. SALE AND LEASEBACK AND LEASE-PURCHASE AGREEMENTS

A. *Sale and Leaseback Agreements—Rental Charges.*—Rental costs specified in sale and leaseback agreements, incurred by providers through selling plant facilities or equipment to a purchaser not connected with or related to the provider and concurrently leasing back the same facilities or equipment are includable in allowable costs if these conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;
2. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost;
3. The leasing was based on economic and technical considerations. If all these conditions are not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

B. *Lease Purchase Agreements—Rental Charges.*—Some lease agreements are essentially the same as installment purchases of facilities or equipment. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs had he had legal title to the asset, such as, for example, straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year

the asset is returned. If the asset continues to be rented after the due date for the purchase, and rental has been reduced, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair market rental value.

The existence of the following conditions will generally establish that a lease is a virtual purchase:

1. The rental charge exceeds rental charges of comparable facilities or equipment in the area,
2. The term of the lease is less than the useful life of the facilities or equipment; and
3. The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time or times acquisition by the provider is permitted.

112. ALLOWANCE FOR DEPRECIATION ON FACILITIES LEASED FOR A NOMINAL AMOUNT

A considerable number of providers lease their facilities from municipalities at a nominal rental—usually for $1.00 per year—the lease generally covering the useful life of the facility. Under most lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such case the cost of any addition or improvement would be similarly amortized and the amortization allowance would likewise be includable in allowable cost.

It is the general practice of the provider to include in its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse providers on the basis of cost allow depreciation on facilities that have been leased for a nominal rental. In view of the above and since the lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

112.1 Analysis of Lease Arrangement.—Each case must be decided on its own merits for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility. The lease may and frequently does cover the useful life of the asset; however, if the lease does not do so, such as a year to year lease, such lease should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the provider will use the facility to the extent of their useful lives. Where the intent and provisions of the year to year lease permit the provider to have the benefit of the useful life of the facility, such lease should be treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life.

The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free hospital services to the employees of the lessor, then depreciation in such case should not be allowed. In such case, the cost of the services furnished to the lessor's employees would be appropriately included when determining medicare's share of allowable costs.

Where the provider pays or contributes to the lessor any funds which are to be used for retiring the lessor's bonds or notes issued for the facility, such payments will be considered rental payments. These rental payments, to the extent they are reasonable, will be considered an allowable cost; likewise, any general contribution by the lessee to the lessor will be considered a rental payment for the use of the facility. Where either of such rental payments is allowable as cost, depreciation on the leased facility will not be an allowable cost item.

Any questions on the legal interpretation of the lease as it relates to the criteria discussed above, should be submitted through the Bureau of Health

Insurance regional office for an opinion from the regional attorney.

112.2 Basis and Method for Depreciation.—The leased asset should be treated for depreciation cost allowance purposes under the program as though the lessor and lessee were one and the same. All the cost principles and reimbursement manual sections on depreciation would be applicable to such assets. For example, the basis for depreciation will be the historical cost of the asset to the lessor adjusted for past depreciation; and if historical cost records are not available, a proper appraisal for establishing the historical cost would be acceptable. Where the leased facility is later purchased by the provider, the facility's undepreciated balance on the date of title transfer or the purchase price, whichever is lower, will for further depreciation purposes be considered the unrecovered cost of the facility.

The following illustration demonstrates how depreciation would be computed on the leased facility and amortization on improvements made to that facility.

Facts

Historical cost of the leased facility at acquisition date—7/1/56	$520,000
Estimated salvage value	$ 20,000
Estimated useful life of the facility	40 years
Life of the lease effective at 7/1/60	35 years
Method for depreciation	Straight line
Leasehold improvement 7/1/65	$ 90,000
Estimated useful life of improvement	30 years

Computation of Depreciation

Historical cost of building	$520,000	
Less: Estimated salvage value	20,000	
Basis for depreciation	$500,000	
Annual rate of depreciation based on 40 year life	2.5%	
Annual depreciation on building		$ 12,500
Accumulated depreciation on 7/1/66* (10 years @ $12,500)		$125,000

Computation of Amortization on Improvement

Cost of leasehold improvement	$ 90,000	
Useful life—30 years		
Annual amortization	$ 90,000 ÷ 30 years	$ 3,000
Accumulated amortization on 7/1/66 *		$ 3,000

Total Annual Depreciation and Amortization

Annual depreciation on facility	$ 12,500
Annual amortization on improvement	3,000
Total	$ 15,500

* Date of entrance into medicare program.

114. BASIS FOR DEPRECIATION

A. *New Assets.*—The basis for depreciation of new assets under the straight-line and sum-of-the-years' digits methods is the historical cost of the asset (or fair market value in the case of donated assets) less its salvage value. Under the declining balance method, the basis for depreciation is the historical cost only.

B. *Used Assets—Partially or Fully Depreciated on the Providers' Books.*—The adjusted historical cost of the asset as determined below is to be used for determining the basis for depreciation under the three approved methods for depreciation. For the straight-line and sum-of-the-years' digits methods, the basis for depreciation would be the adjusted historical cost reduced by the estimated salvage value. Where the declining balance method is used, the basis for depreciation would be the adjusted cost of the asset.

The adjusted historical cost of an asset that is in use when the provider enters the program is its historical cost reduced by the depreciation accumulated up to the date of entrance into the program. Accumulated depreciation for this purpose may be determined on a straight-line basis (regardless of the depreciation method used or in use by the provider) and based on an estimate of the asset's useful life taking into account past and current information. Thus, if an asset currently in use has been fully depreciated on the provider's books it would be evident that an asset's useful life has not ended. Consequently, a new estimate of the asset's useful life, based on current information, may be made.

The following examples illustrate how the basis for depreciation is determined for used assets:

Facts

Historical cost of the asset	$25,600
Estimated salvage value	$ 1,600

Asset acquired on July 1, 1962.
Original estimated useful life is eight years.
On July 1, 1966, the asset's useful life is estimated to be twelve years from date of acquisition.

1. ***Provider had previously used straight-line method for depreciation—Assets partially depreciated***

Accumulated depreciation on the books	$12,000
Accumulated depreciation for medicare purposes:	
Historical cost	$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	$24,000
Adjusted accumulated depreciation (4/12 x $24,000)	8,000
Adjusted historical cost:	
Historical cost	$25,600
Less: Adjusted accumulated depreciation	8,000
Adjusted historical cost	$17,600
Basis for depreciation under the program:	
Declining balance method of depreciation:	
(Adjusted historical cost)	$17,600

Straight-line and sum-of-the-years' digits methods:

Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

2. *Provider had previously used sum-of-the-years' digits for depreciation—Assets partially depreciated*

Accumulated depreciation on the books	$17,333
Accumulated depreciation for medicare purposes:	
Historical cost	$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	$24,000
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x $24,000)	$ 8,000
Adjusted historical cost:	
Historical cost	$25,000
Less: Adjusted accumulated depreciation	8,000
Adjusted historical cost	$17,600
Basis for depreciation under the program:	
Declining balance method (Adjusted historical cost)	$17,600
Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

3. *Provider had previously used declining balance method—Asset partially depreciated*

Accumulated depreciation on the provider's books	$17,500
Accumulated depreciation for medicare purposes:	
Historical cost	$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	$24,000
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x $24,000)	$ 8,000
Adjusted historical cost:	
Historical cost	$25,600
Less: Adjusted accumulated depreciation	8,000
Adjusted historical cost	$17,600
Basis for depreciation under the program:	
Declining balance method (Adjusted historical cost)	$17,600
Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	$17,600
Less: Estimated salvage value	1,600
Basis for depreciation	$16,000

116. DEPRECIATION METHODS

Three methods are acceptable for computing depreciation, namely the straight-line, sum-of-the-years' digits, and declining balance methods. However, the accelerated methods of depreciation—sum-of-the-years' digits and declining balance may be used only if the assets' expected useful life under the program is more than three years. Regardless of the method of depreciation being used, an asset should not be depreciated below its salvage value. (See § 104.19 on Salvage Value.) No additional first year bonus depreciation is allowable. A provider may elect any one of the three acceptable methods. A formal election procedure is unnecessary for depreciable assets held at the time of entrance in the program or for assets subsequently acquired. The depreciation method used in claiming depreciation on a particular asset for the first time will be presumed to be the depreciation method selected for that asset. A provider need not use the same method for all depreciable property. Also, a provider may elect to use a different depreciation method for similar property acquired later. However, if a provider wishes to change methods, a formal request and approval by the fiscal intermediary will be necessary as explained under the "Change of Depreciation Method" section.

116.1 Straight-line Method.—Under this method the annual allowance is determined by dividing the cost of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year. The following examples illustrate how depreciation is computed:

NEW ASSET

Facts:	Acquisition cost	$17,000
	Estimated salvage value	2,000
	Estimated useful life	5 years

Annual depreciation is computed as follows:

Acquisition cost	$17,000
Less: Estimated salvage value	2,000
Basis for depreciation	$15,000

$$\frac{\text{Basis for depreciation}}{\text{Useful Life}} = \text{Depreciation per annum}$$

$$\frac{\$15,000}{5 \text{ years}} = \$3,000 \text{ each year}$$

The annual allowance can also be computed by using a percentage applied to the basis for depreciation. For example, in the above illustration, a five year life produces a 20% rate (100%/5 years). This 20% rate when applied to the $15,000 basis for depreciation results in an annual $3,000 depreciation allowance for each of the five years.

USED ASSET

Facts:	Historical cost	$46,000
	Salvage value	1,000
	Estimated useful life	15 years
	Years asset used by provider before entrance into program	10 years
	Straight-line method of depreciation to be used for medicare purposes.	

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the basis for depreciation as follows:

Cost	$46,000
Deduct: Salvage value	1,000
Balance	$45,000

Deduct: Accumulated depreciation under the straight-line method for 10 years

$$\frac{(10 \text{ years} \times \$45{,}000)}{15 \text{ years}} = \$30{,}000$$

Basis for depreciation ---------- $15,000

c. Divide the basis for depreciation by the number of years of remaining life:

$$\frac{\text{Item b}}{\text{Item a}} = \frac{\$15{,}000}{5 \text{ years}} = \$3{,}000 \text{ annual depreciation}$$

116.2 Sum-of-the-years' Digit Method.—Under this method, the annual depreciation allowance is computed by multiplying the basis for depreciation (cost less estimated salvage value) by a constantly decreasing fraction. The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year and the denominator represents the sum of the years of estimated useful life at the time of acquisition in case of new assets or at time of entrance into the program in the case of used assets. The following example illustrates how depreciation is computed.

NEW ASSET

Facts: Cost ---------- $17,000
Estimated salvage value ---------- 2,000
Estimated useful life ---------- 5 years

Depreciation is computed as follows:

a. Add each number in the estimated useful life (5 years: $1 + 2 + 3 + 4 + 5 = 15$).
b. Use the sum 15 as the denominator of the fraction.
c. Each year, for the numerator of the fraction use the remaining years of useful life including the year for which depreciation is taken. This means using each number in a. above in inverse order (5,4,3,2,1) i.e., 5 for the first year, 4 for the second year, 3 for the third year, etc.
d. Multiply the basis for depreciation by this fraction ($\frac{c}{b}$)

Cost ---------- $17,000
Salvage ---------- 2,000
Basis for depreciation ---------- $15,000

Annual Computation

Year	*Basis for Depreciation*	*Ratio*	*Annual Depreciation Allowance*
1st	$15,000	× 5/15 =	$5,000
2nd	15,000	× 4/15 =	$4,000
3rd	15,000	× 3/15 =	$3,000

USED ASSET

Facts: Cost ---------- $46,000
Salvage value ---------- 1,000
Estimated useful life ---------- 15 years
Provider used the asset (prior to entrance into the program) for ---------- 10 years

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).
b. Add each number of the remaining years of useful life ($5 \text{ years} = 1 + 2 + 3 + 4 + 5 = 15$).
c. Use the sum 15 as the denominator of the fraction.
d. Each year, for the numerator of the fraction use the remaining years of useful life including the year in which depreciation is taken. This means using each number in (b) above in inverse order (5,4,3,2,1), i.e., 5 for the first year under the program, 4 for the second year under the program, 3 for the third under the program, etc.
e. Determine the basis for depreciation as follows:

Cost ---------- $46,000
Deduct: Salvage value ---------- 1,000
Balance ---------- $45,000
Deduct: Accumulated depreciation under straight-line method for 10 years

$$(\$45{,}000 \times \frac{10 \text{ yrs.}}{15 \text{ yrs.}})$$ $30,000

Basis for depreciation ---------- $15,000

f. Multiply the basis for depreciation (e) by the fraction ($\frac{d}{c}$) to determine annual depreciation.

Annual Computation

Year	*Basis*	*Ratio*	*Annual Depreciation Allowance*
1st	$15,000	× 5/15 =	$5,000
2nd	$15,000	× 4/15 =	$4,000
3rd	$15,000	× 3/15 =	$3,000

116.3 Declining Balance Method.—Under this method the annual allowance is computed by multiplying the undepreciated balance of the asset each year by a uniform rate up to double the straight-line rate. Salvage value is not considered in computing the depreciation allowance. However, under this method, the asset should not be depreciated below the estimated salvage value.

NEW ASSET

Facts: Cost ---------- $17,000
Salvage value ---------- 2,000
Estimated useful life ---------- 5 years
Rate to be used ----------Double the straight-line rate: 2 × 20% = 40%

Annual Depreciation is computed as follows:

Year	*Undepreciated Balance*	*Rate*	*Annual Depreciation Allowance*
1st	$17,000	× 40% =	$6,800
2nd	10,200	× 40% =	$4,080
3rd	6,120	× 40% =	$2,448

USED ASSETS

Facts: Cost ---------- $46,000
Salvage value ---------- 1,000
Estimated useful life ---------- 15 years
Provider used the asset (prior to entrance into the program) ---------- 10 years
Double the straight-line rate to be used under the program.

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life. (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the straight-line rate for the remaining years of useful life ($\frac{100\%}{5 \text{ yrs.}} = 20\%$).

c. Double the straight-line rate ($2 \times 20\% = 40\%$).

d. Determine the basis for depreciation as follows:

Cost	$46,000
Deduct: Salvage value	1,000
Balance	$45,000
Deduct: Accumulated depreciation under straight-line method for 10 years $45,000 \times \frac{10 \text{ years}}{15 \text{ years}}$	$30,000
Balance	$15,000
Salvage value	1,000
Basis for depreciation (or unrecovered cost in first year under the program)	$16,000

e. Multiply each year's undepreciated balance (or unrecovered cost) by 40% (Note: Do not depreciate the asset below its salvage value).

Year	*Undepreciated Balance*		*Rate*	*Annual Allowance Depreciation*
1st	$16,000	×	40%	$6,400
2nd	$ 9,600	×	40%	$3,840
3rd	$ 5,760	×	40%	$2,304
4th	$ 3,456	×	40%	$1,382
5th	$ 2,074	×	40%	$ 830

116.4 Comparison of Depreciation Methods.

A comparison of annual depreciation under each of the three acceptable methods of computing depreciation is reflected in the following table. (Salvage value at the end of the fifth year is $2,000):

	Straight-line		***Sum-of-the-years' Digits***		***Double Declining Balance***	
	Rate:—20%		(5/15, 4/15, 3/15, etc.)		(40%)	
Year	Undepreciated Balance	Annual Allowance	Undepreciated Balance	Annual Allowance	Undepreciated Balance	Annual Allowance
	$17,000		$17,000		$17,000	
	—2,000	(Salvage Value)	—2,000	(Salvage Value)	—0	(No Salvage Value)
1st	$15,000	$ 3,000	$15,000	$ 5,000	$17,000	$ 6,800
2nd	12,000	3,000	10,000	4,000	10,200	4,080
3rd	9,000	3,000	6,000	3,000	6,120	2,448
4th	6,000	3,000	3,000	2,000	3,672	1,469
5th	3,000	3,000	1,000	1,000	2,203	203*
		$15,000		$15,000		$15,000

* Although depreciation at 40% of the undepreciated balance would amount to $881, this amount cannot be used because an asset cannot be depreciated below its salvage value, and $881 would bring the undepreciated balance below salvage value ($2,000). Instead, however, the amount of depreciation to be taken for the fifth year would be the amount that would bring the undepreciated balance to the salvage value:

Undepreciated balance at beginning of 5th year	$2,203
Maximum depreciation for 5th year	203
Undepreciated balance at end of 5th year equal to salvage value	$2,000

118. DETERMINING DEPRECIATION IN YEAR OF ACQUISITION AND DISPOSAL

The amount of depreciation recorded during the year of acquisition and year of disposal varies among providers. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the intermediary. Whatever method is adopted, it must be applied to all assets subsequently acquired.

A. *Time Lag Alternatives.*—These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain extended time intervals.

1. Up to 6 Months Time Lag—Assets acquired during the first 6 months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year.

 Assets acquired during the second 6 months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year.

 Depreciation on disposal is based on the portion of the year in which the asset is disposed. If the asset is disposed of in the first half of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year a full year's depreciation is taken.

2. Up to One Year Time Lag—Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

 Note: A variation of the above methods by use of a quarterly or monthly basis for determining depreciation in the first year and the year of disposal, would be acceptable.

B. *Half Year Depreciation.*—One half year depreciation is taken in the year of acquisition regardless of acquisition date and one half year depreciation is taken on disposition regardless of disposition date.

C. *Actual Time Depreciation.*—Depreciation for the first reporting period is based on the length of time

from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed to the date of disposal.

120. CHANGE OF DEPRECIATION METHOD

Generally, a provider will adhere to the particular depreciation method or methods selected initially until final depreciation of the asset. After the initial selection, a provider may change only once to any of the other allowable methods, provided advance approval has been obtained from the intermediary. A request for change in the depreciation method must be made no later than the last day of the first month of the accounting year in which the new method is to be employed.

If the new method of depreciation is the straight-line or sum-of-the-years' digits, the basis for depreciation will be the undepreciated balance (unrecovered cost) reduced by the salvage value. If the new method of depreciation is the declining balance, the basis for depreciation will be the undepreciated balance (un recovered cost).

The new basis for depreciation will be treated as though it were the basis for depreciation of a new asset, and depreciation would be based on the remaining years of useful life. (In this respect see computation of depreciation on "used" assets under the particular method of depreciation.)

122. CHANGING ESTIMATED USEFUL LIFE

A. *Assets Acquired after Provider's Entrance into the Program.*—When the estimate of the useful life of such an asset is changed, the undepreciated balance as of the date of change is depreciated over the new remaining useful life. The following examples illustrate how the new annual depreciation is computed under the *accelerated* methods of depreciation.

EXAMPLE #1—*Declining balance method.*

An asset costing $10,000, and having an estimated useful life of 10 years has been depreciated for 6 years at the declining balance rate of 20%. The depreciation accumulated during the 6 years is $7,378.60, and the undepreciated balance is $2,621.40.

At the end of the sixth year, it is determined that the remaining useful life is 8 years. Accordingly, future depreciation must be computed as though the estimate of useful life was originally determined to be 14 years. The applicable depreciation rate would be 14²⁄₇% (twice straight-line rate of 7¹⁄₇%). This rate would be applied to the undepreciated balance. Thus, for the 7th year the depreciation would be 14²⁄₇% times $2,621.40—or—$374.49.

EXAMPLE #2—*Sum-of-the-years' digits method.*

An asset having an estimated useful life of 10 years is purchased for $10,500. Salvage value is estimated at $500. After five years the accumulated depreciation under the sum-of-the-years' digits method amounts to $7,272.70; the undepreciated balance of the cost is $3,227.30. At the beginning of the sixth year it is determined that the asset has 9 years more of useful life.

Depreciation for the sixth year should be computed as though the sixth year were the first year of life on an asset estimated to have a useful life of 9 years. Accordingly, the depreciation for the sixth year (or first year under the new estimate) would be computed as follows:

Basis for depreciation:	
Unrecovered cost	$3,227.30
Less: Salvage value	500.00
Basis for depreciation	$2,727.30
Sum-of-the-years' digits (1+2+3, etc . . . +9) =	45
Depreciation = 9/45 × $2,727.30 =	$ 545.46

B. *Assets Acquired before Provider's Entrance into the Program.*—Where a change is made in the estimate of the useful life of an asset that was acquired before the provider's entrance into the program, it will be necessary to correct prior year's depreciation for both the periods before and after entrance into the program. The following example illustrates how the correction is computed.

EXAMPLE

Facts:

Asset acquired 3 years before entrance into program.	
Historical cost of the asset	$30,500
Estimated remaining useful life at entrance into program	7 years
Estimated salvage value	$ 500
Straight-line depreciation used under the program.	
At beginning of 5th year under the program it is estimated that the asset has 8 more years of useful life.	

Computation of depreciation for the 5th year under the program

New estimated useful life	15 years
3 years before the program	
4 years under the program	
8 years more useful life	
15 years of useful life	
Historical cost	$30,500
Depreciation accumulated prior to program	
3 years × ($30,500–$500 salvage value) / 15 years	6,000

Adjusted historical cost	$24,500
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	$24,000
Annual depreciation under the program $\frac{\$24,000}{12 \text{ years of useful life under program}} =$	$ 2,000
Depreciation for the fourth year and annually thereafter is	$ 2,000
Correction of prior years' depreciation	
Original estimated useful life	10 years
Historical cost	$30,500
Depreciation accumulated prior to program on basis of estimate of 10 years' useful life $3 \text{ years} \times \frac{(\$30,500-\$500)}{10 \text{ years}} =$	9,000
Adjusted historical cost	$21,500
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	$21,000
Depreciation that was taken under the program in four years $4 \text{ years} \times \frac{\$21,000}{7 \text{ years}}$	$12,000
Corrected depreciation for four years under the program based on estimated useful life of 15 years (4 years × $2,000 annual depreciation)	8,000
Reduction of prior years' depreciation under the program	$ 4,000*

* Reduction of $4,000 must be applied to current year's depreciation.

124. OPTIONAL ALLOWANCE FOR DEPRECIATION BASED ON A PERCENTAGE OF OPERATING COST

For all depreciable assets acquired before January 1, 1966, the provider, at its option, may at the time it enters the program choose an allowance for depreciation based on a percentage of operating costs. This option is available to any provider, regardless of whether or not the provider has historical cost records of these assets. However, a provider that has elected to use actual depreciation cannot at a later date switch to the optional allowance.

The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percentage to be applied is 5 percent for all reporting periods beinning in the year 1966–67 (July 1, 1966—June 30, 1967); 4½ percent for all reporting periods beginning in the year 1967–68 (July 1, 1967—June 30, 1968), with such percentage being uniformly reduced by one-half percent each succeeding year.

The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965. However, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965, and the estimated depreciation on a straight-line basis on all rented assets used during the current year may not exceed 6 percent of the provider's adjusted allowable cost for the current year. In applying this limitation, if the actual depreciation claimed on post-1965 assets is on an accelerated basis, it must be converted to a straight-line basis only for use in computing this limitation. The actual depreciation claimed on an accelerated basis is properly includable in allowable costs.

124.1 Definitions.—

A. *Operating Costs.*—Operating costs are the total costs, related to patient care, incurred by the provider in operating the institution or facility.

B. *1965 Operating Costs.*—1965 Operating costs are the provider's operating costs incurred in the provider's fiscal year beginning in the period 8/1/64—7/31/65 without adjustment to medicare's principles of reimbursement for provider costs. When the 1965 operating costs are used as a base for determining the optional allowance for depreciation, such costs must be adjusted to exclude the estimated depreciation on rented depreciable type assets or the rental charge for such assets whichever is lower; and in addition, the 1965 operating cost must not include any actual depreciation, an amount in lieu of specific recognition of other costs, "a plus factor," or return on equity capital.

C. *Allowable Costs.*—Allowable costs are those costs includable in cost reimbursement under the medicare principles of reimbursement for provider costs. When the current year's allowable costs are used as a base for the optional allowance for depreciation, they should be adjusted to exclude (1) any actual depreciation, (2) the lesser of rental charges or estimated depreciation on rented depreciable type assets, (3) allowance in lieu of specific recognition of other costs, and (4) return on equity capital. The exclusion of these four items is only for the purpose of computing the optional allowance for depreciation. For other purposes, rental charges and excluded items (1), (3), and (4) are recognized in determining allowable costs and for computing the costs of services rendered to the program beneficiaries during the reporting period.

Where a provider files a short-period report, the allowable costs must be converted to a full year's basis (see example 3) only for the purpose of computing the optional allowance.

124.2 Applicable Percentages.—The percentage to be applied in each reporting year is shown in the following schedule:

Reporting year beginning *After*	but *Before*	*Percentage Allowance*
-------	7/1/67	5
6/30/67	7/1/68	4½
6/30/68	7/1/69	4
6/30/69	7/1/70	3½
6/30/70	7/1/71	3
6/30/71	7/1/72	2½
6/30/72	7/1/73	2
6/30/73	7/1/74	1½
6/30/74	7/1/75	1
6/30/75	7/1/76	½
6/30/76	7/1/77	0

124.3 Computation of Optional Allowance for Depreciation.—The following illustrates the determination of the optional allowance for depreciation based on operating costs:

EXAMPLE 1

Facts:

The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current year's allowable cost has been adjusted to remove any allowance in lieu of specific recognition of other costs and return on equity capital.

Computation

First Reporting Period (1/1/66–12/31/66)

Adjusted current year's allowable cost	$1,100,000
Operating cost for 1965 [1]	$1,000,000
Percent for determining the allowance	5%
Allowance (5% × $1,000,000)	$ 50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

Second Reporting Period (1/1/67–12/31/67)

Adjusted current year's allowable cost	$1,200,000
Operating cost for 1965 [1]	$1,000,000
Percent for determining the allowance [2]	5%
Allowance (5% × $1,000,000)	$ 50,000

[1] 1965 operating cost was used in computing the allowance for depreciation because it was lower than 1967 adjusted allowable cost.

[2] Since the reporting period began during the year 1966–67 (July 1, 1966–June 30, 1967) 5 percent is the percentage to be used.

Third Reporting Period (1/1/68–12/31/68)

Operating cost for 1965	$1,000,000
Current year's adjusted allowable cost [1]	$ 900,000
Percent for determining the allowance [2]	4½%
Allowance (4½% × $900,000)	$ 40,500

[1] The current year's adjusted allowable cost was used in computing the allowance for depreciation because it was lower than 1965 operating cost.

[2] Since the reporting period began during the year 1967–68 (July 1, 1967–June 30, 1968) 4½ percent is the percentage to be used.

EXAMPLE 2

Facts:

The provider keeps its records on a *calendar year basis.* The current year actual allowable cost and the actual operating cost for 1965 did not include any actual depreciation, nor return on equity capital. However, both 1965 and the current year's costs have been adjusted to exclude depreciation ($3,000 for 1965, $2,000 for the current year) on rented depreciable type assets. The current year's allowable cost has also been adjusted to remove the allowance in lieu of specific recognition of other costs and return on equity capital.

Computation

First Reporting Period (1/1/66–12/31/66)

Adjusted current year's allowable cost	$1,100,000
Adjusted operating cost for 1965 [1]	$1,000,000
Percent for determining the allowance	5%
Allowance (5% × $1,000,000)	$ 50,000
Less: Estimated depreciation for depreciable type assets on which rental of $5,000 is paid in 1966	$ 3,000
Adjusted allowance	$ 47,000

[1] 1965 adjusted operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

EXAMPLE 3

Facts:

The provider keeps its records on a calendar year basis. The provider's first report will be a short period one of six months, July 1, 1966–December 31, 1966. The current year's actual allowable cost and the actual operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current year's allowable cost has been adjusted to remove the allowance in lieu of specific recognition of other costs.

Computation

First Reporting Period (7/1/66–12/31/66)

Adjusted current year's allowable cost (6 months)	$ 575,000
Adjusted current year's allowable cost converted to a 12-month period (2 × $575,000)	$1,150,000
Operating cost for 1965 [1]	$1,000,000
Percent for determining allowance	5%
Allowance (5% × $1,000,000)	$ 50,000

[1] 1965 operating cost was used in computing the allowance for depreciation because it was lower than the adjusted allowable costs covering a 12-month period.

Second Reporting Period (1/1/67–12/31/67)

Adjusted current year's allowable cost	$1,200,000
Adjusted operating cost for 1965 [1]	$1,000,000
Percent for determining the allowance	5%
Allowance (5% × $1,000,000)	$ 50,000
Less: Estimated depreciation for depreciable type assets on which a rental of $5,000 is paid in 1967	3,000
Adjusted allowance	$ 47,000

[1] 1965 adjusted operating cost was used in computing the allowance for depreciation because it was lower than the 1967 adjusted allowable costs.

124.4 Limitation.—The optional allowance only —not the actual depreciation—is subject to a limitation based on the provider's total allowable operating cost for the current year. To determine this limitation, compute the sum of (a) the actual depreciation

claimed for post-1965 assets computed on a straight-line basis, (b) "the optional allowance based on a percentage of operating costs," and (c) estimated depreciation on depreciable type rented assets used in the current year. If this sum exceeds 6 percent of the provider's current year's adjusted allowable cost (allowable cost reduced by any depreciation claimed, the estimated depreciation on rented depreciable type assets, alowance in lieu of specific recognition of other costs, and return on equity capital), the optional allowance for depreciation must be reduced by the amount of the excess. In applying this limitation if the actual depreciation is on an accelerated basis, it must be converted to a straight-line basis *only* for use in calculating this limitation.

Where the provider files a short-period report, the period's allowable costs, after adjustment to exclude the 4 items mentioned above, must be converted to a full year's basis (see Example 3). Thus if the short-period report is for 8 months, the adjusted allowable costs should be increased by 50%; if the short period is for 9 months, the adjusted allowable cost should be increased by 33⅓%, etc. In addition, the actual depreciation computed on a straight-line basis as well as the estimated depreciation on rented depreciable type assets must be converted to a 12-month or full year's basis.

The following illustration demonstrates how the limitation is determined:

EXAMPLE 4

Facts:

The provider keeps its records on a calendar year basis. For its first report, the provider will use a 6 month's period. The current year's actual allowable cost and the actual operating cost for 1965 have been adjusted to exclude actual depreciation, the estimated depreciation on rented depreciable type assets, allowance in lieu of specific recognition of other costs, and return on equity capital.

Adjusted operating cost for 1965	$1,000,000
Adjusted allowable operating cost for the last 6 months of 1966	$ 550,000
In 1966, assets were acquired which produced for 1966 a straight-line depreciation of	$ 18,000
Estimated depreciation for the year on rented assets used in 1966	$ 4,000
Estimated annual depreciation on assets rented for which an annual rental of $5,000 is paid	$ 3,000

Computation of the Optional Allowance

First Reporting Period (7/1/66–12/31/66)

Adjusted allowable costs for the last 6 months of 1966 *converted to* a 12 month basis (2 × $550,000)	$1,100,000
Gross optional allowance: 5% of adjusted 1965 operating cost ($1,000,000) [1]	$ 50,000
Less: Estimated depreciation on assets rented	3,000
Gross allowance	$ 47,000
Add: Estimated depreciation for the year on rented assets used in 1966	4,000
Straight-line depreciation on post-1965 assets for 12 months	18,000
Total	$ 69,000
6% of adjusted 1966 allowable operating cost (6% × $1,100,000)	66,000
Deduction in allowance	$ 3,000
Gross Allowance	$ 47,000
Less: Reduction for excess of 6% limitation	3,000
Net optional allowance for the year	$ 44,000
Net optional allowance converted to a 6 month period ($44,000 ÷ 2)	$ 22,000

[1] The adjusted 1965 operating cost is used because it is lower than the adjusted allowable cost converted to a 12 months' period.

Second Reporting Period (1/1/67–12/31/67)

Facts:

Adjusted allowable cost for 1967	$1,150,000
Adjusted operating cost for 1965	1,000,000
Percent for determining the allowance	5%
Straight-line depreciation on assets acquired after 1965	$ 20,000
Estimated depreciation on $7,000 rental of depreciable type assets used in 1967	4,000
Estimated depreciation on depreciable assets rented on which annual rental of $5,000 is paid	3,000

Computation:

Gross Optional Allowance

5% times adjusted 1965 operating cost (5% × $1,000,000)	$ 50,000
Less: Estimated depreciation on depreciable assets rented	3,000
Adjusted allowance	$ 47,000
Add: Straight-line depreciation on post-1965 assets	20,000
Estimated depreciation on depreciable rented assets used in 1967	4,000
Total	$ 71,000
Less: 6% of adjusted 1967 allowable operating cost	$ 69,000
Deduction to adjusted allowance	$ 2,000
Net allowance to be included in allowable cost:	
Adjusted allowance	$ 47,000
Less: Deduction to adjusted allowance	2,000
Net allowance	$ 45,000

126. CHANGE FROM OPTIONAL ALLOWANCE TO ACTUAL DEPRECIATION

A provider that elects the optional allowance for depreciation may at any time before 1976 change to actual depreciation on its pre-1966 assets. When a provider switches to actual depreciation it can no longer elect the optional allowance.

When a provider changes to actual depreciation, the

depreciation accumulated to the date of change will be determined in the same manner as accumulated depreciation is determined for used assets when a provider enters the program. Upon disposition of the asset, the determination of gain or loss will be made on the basis of historical cost depreciation for the actual useful life of the asset.

128. ESTIMATED DEPRECIATION PENDING APPRAISAL

For those providers not wishing to use the optional method of depreciation and who have signed contracts to have appraisals made to establish the cost of pre-1966 assets, a reasonable estimate of the actual depreciation may be made, pending completion of the appraisal. Such an appraisal must be completed within two years of the contract date. Until the appraisal is completed an estimated depreciation may be taken for the current cost report, with a retroactive adjustment to the estimated depreciation to be made when the appraisal is completed.

128.1 Limitation.—The estimated depreciation may not exceed 5 percent of 1965 operating costs or the current year's allowable costs, as adjusted for computing the optional allowance for depreciation, whichever is lower. The total alowable estimated depreciation is also subject to an adjustment based on the provider's adjusted allowable cost for the current year. To determine this limitation, compute the sum of (a) the actual depreciation claimed for post-1965 assets determined on a straight-line basis, (b) estimated depreciation on rented depreciable type assets used in the current year, and (c) the estimated deprciation on pre-1966 assets. If this sum exceeds 6 percent of the provider's adjusted current year's allowable cost (allowable cost exclusive of any depreciation claimed, estimated depreciation on rented depreciable type assets, allowance in lieu of specific recognition of other costs and return on owner's equity capital), the reasonable estimated depreciation must be reduced by the amount of the excess.

When the appraisal has been completed, actual depreciation must be computed for the year(s) in which estimated depreciation was taken and compared with the amount of depreciation claimed on the cost report(s). The provider may either submit amended cost report(s) for the year(s) in question or it may adjust the current year's depreciation to reflect the difference between the estimated depreciation and depreciation based on the appraisal of the asset's historical cost. Any current year adjustment must reflect the medicare percentages of participation for the year(s) in question applied to the difference between the estimated depreciation and depreciation based on the appraisal.

130. DISPOSAL OF ASSETS

Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed.

Where an asset has been retired from active service, but is being held for stand-by or emergency services, depreciation may continue to be taken on such assets. However, where the asset has been permanently retired or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

132. GAINS AND LOSSES ON DISPOSAL OF DEPRECIABLE ASSETS

Gains and losses on the disposition of depreciable assets are includable in computing allowable costs. However, gain on the disposal of an asset must not exceed the depreciation accumulated for that asset under the program.

If the gains or losses on the disposal of depreciable assets in a reporting period are greater than ten percent (10%) of the total allowable depreciation for the period, the amount of the excess gain or loss over the ten percent (10%) must be carried forward over the five succeeding years. The identity of the gain or loss carry-forward for each individual year must be maintained in the records. The carry-forward must be considered first in determining the ten percent limitation for the current year.

132.1 Computation of Gain or Loss on Assets Acquired Before the Provider's Entrance into the Program.—When an asset that was acquired before entrance into the program is disposed of, a correction of prior years' depreciation based on *actual* useful life must be made before determining any gain or loss. The actual useful life will cover the period from date of acquisition to date of disposal. The depreciation accumulated before and after entrance into the program must be corrected in the same manner as when making a new estimate of the asset's useful life. (See § 122) The gain or loss is the difference between the amount received for the disposed asset and the corrected undepreciated cost at

the time of sale. However, where an asset is traded-in for another asset there will be neither a gain nor loss on the disposition. (See § 104.11 for determining the cost of new asset when a trade-in is involved.)

The following example illustrates how to compute gain or loss on disposal of an asset that was acquired before entrance into the program:

EXAMPLE

Facts:

Asset acquired 10 years before entrance into the program	10 years
Estimated remaining useful life at entrance into program	20 years
Total useful life	30 years
Estimated Salvage Value	$ 10,000
Historical cost	$310,000
Salvage Value	10,000
Sum-of-the-years' digits method of depreciation used under the program	$300,000
Accumulated depreciation before entrance into program (using straight-line depreciation)	100,000
Undepreciated balance subject to depreciation under the program	$200,000
Asset sold at the end of the 15th year under the program for	$ 1,000
Depreciation accumulated under program for 15 years	$185,714

Computation of Gain or Loss

Historical cost	$310,000
Corrected accumulated depreciation upon entering program—	
$10 \text{ years} \times \frac{\$300{,}000}{25 \text{ years}} =$	120,000
Undepreciated balance subject to depreciation under the program	$190,000
Less: Estimated salvage value	10,000
Basis for depreciation—also, total depreciation allowable under the program	$180,000
Historical cost	$310,000
Accumulated depreciation before and after entrance into program ($120,000 + $180,000)	300,000
Unrecovered cost	$ 10,000
Sales price	1,000
Loss	$ 9,000
Share of loss under program = $\frac{15 \text{ yrs (medicare)}}{25 \text{ yrs (useful life)}} \times \$9{,}000 =$	$ 5,400
Correction of accumulated depreciation under the program:	
Depreciation taken $185,714	
Correct depreciation 180,000	
Excess depreciation taken	5,714
Reduction of depreciation for the year	$ 314

132.2 Computation of Gain or Loss on Assets Acquired Under the Program.—Gain or loss on the disposal of assets acquired under the program is the difference between the sale price of the asset and the asset's unrecovered cost.

EXAMPLE

Facts:

Asset acquired for	$310,000
Estimated life	30 years
Estimated salvage value	$ 10,000
Asset sold at end of 25th year for	$ 25,000
Sum-of-the-years' digits used in depreciating asset—	
Depreciation for 25 years	$290,325

Computation of Gain or Loss

Sales price of asset		$ 25,000
Less: Unrecovered cost:		
Historical cost	$310,000	
Deduct: Accumulated Depreciation for 25 years	290,325	19,675
Gain on disposal		$ 5,325

HD7102 U4 A3 no 15 1968 no 4

HEALTH INSURANCE FOR THE AGED

PROVIDER REIMBURSEMENT MANUAL

REVISION

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
HIM-15

NOVEMBER 1968 No. 4

New Material	No. of Pages
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Chapter 12	8
Chapter 23	8

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This transmittal furnishes the following chapters for inclusion in the Provider Reimbursement Manual.

Chapter 2, Interest Expense, interprets the principle concerning the recognition of interest expense as an allowable cost. Particular attention should be directed to the treatment of deposits to, and withdrawals from, the provider's restricted funds, the funded depreciation account, and qualified pension fund.

Chapter 12, Return on Equity Capital of Proprietary Providers, relates to the determination of average equity capital and the computation of the allowable return thereon.

Chapter 23, Adequate Cost Data and Cost Finding, explains and illustrates the principle that requires providers receiving payment on the basis of reimbursable cost to furnish adequate cost data based on financial and statistical records which can be verified by qualified auditors.

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Bureau of Health Insurance

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INTEREST EXPENSE

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Chapter 2

INTEREST EXPENSE

200. Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

202. Definitions

202.1 Interest

Interest is the *cost incurred for the use of borrowed funds,* generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for one year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. *Interest may be included in "finance charges" imposed by some lending institutions* or it may be a prepaid cost or "discount" in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service charges together with interest on indebtedness are includable in allowable cost.

To be allowable under the Medicare program, interest must be: (1) supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required; (2) identifiable in the provider's accounting records; (3) related to the reporting period in which the costs are incurred; and (4) necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

To support the existence of a loan, the provider should have available a signed copy of the loan contract which should contain the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., will be acceptable.

Where funds are borrowed from the provider's funded depreciation account or other restricted funds, authorization from appropriate officials of the provider should be on file. Appropriate officials of the provider would include the persons to whom responsibility for the management of the restricted amounts or funds has been granted, such as the board of trustees, financial committees, or other individuals or groups, as appropriate in the particular case.

Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement.

Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from the provider premises such as in a county treasurer's office, such records will be deemed to be those of the provider. This would be applicable where bond issues have been specifically designated for the construction or acquisition of the provider's facilities and the financial records relative to the bond issue are maintained by some governmental body other than the provider.

202.2 Necessary

Necessary means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the provider's operations, interest expense is not allowable; such a loan is not considered "necessary." Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost.

Necessary also requires that the interest be reduced by investment income. There is an exception to this general rule where the investment income is from grants and gifts, whether restricted or unrestricted, and which are not commingled with other

funds. "Not commingled" means that the funds are kept physically separate in a separate bank account and not simply recorded separately in the provider's accounting records.

202.3 Proper

Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arms-length transaction in the money market when the loan was made. In addition, the interest must be paid to a lender not related to the provider through common ownership or control. (See Chapter 10, "Cost to Related Organizations" for the definition of common ownership and control.) An exception to the general rule regarding interest on loans from controlled sources of funds is provided in Sections 218.2 and 220.

Where a provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is included in allowable cost, at a rate not to exceed the interest rate the fund is currently earning.

202.4 Prepaid Interest

Prepaid interest is the excess of the face value of a loan over the proceeds of the loan. It is the payment of interest in advance of the period over which the interest expense is incurred.

202.5 Finance Charges

Some lending institutions include in the costs of loans, expenses related to the maintenance of records, collection of delinquent accounts, administration, etc., in addition to the charges for interest. The total of all these costs is known as finance charges, carrying charges, etc. The interest portion of these costs should be so identified in the provider's accounting records since interest must be eliminated in the computation of the "Allowance in Lieu of Specific Recognition of Other Costs." (See Chapter 11.) When service charges are not separated from interest, the entire amount must be eliminated in applying the provisions of Chapter 11.

204. Mortgage Interest

A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other fixed assets.

Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That portion which is for the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable.

In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

206. Interest During Period of Construction

Frequently, providers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be *capitalized* as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction is included in the capitalized cost of the facility constructed.

208. Interest on Loans Covering Multiple Facilities

Where a loan is made to construct, or acquire, a number of buildings (or other fixed assets), the interest on the loan applies to the several assets acquired in proportion to the cost each asset bears to the total cost of the assets. If any building or other asset covered by the loan is not used for purposes related to patient care, the interest applicable to such asset is *not allowable* as a cost of patient care. The proportionate part of such interest applicable to assets used for patient care is an allowable cost.

Examples of fixed assets which might be purchased under a single loan agreement could be land,

buildings, and equipment to be used by the provider in furnishing services to patients, and additional land to be held for future expansion. The land purchased in anticipation of expansion would not be considered related to patient care.

Interest expense for this type of acquisition would be allowable as follows:

Total Amount of Mortgage	$500,000
Land, Buildings, and Equipment Related to Patient Care	$400,000
Land Acquired for Future Expansion	$100,000

In the above situation, 80% ($400,000÷$500,000) of the mortage interest would be includable in allowable costs, while 20% ($100,000÷$500,000) would not be includable in allowable costs.

210. Interest on Notes

A note is contractual evidence given by a borrower to a lender that funds have been borrowed and which states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note. Frequently, a note is issued as an instrument evidencing a loan which may have a term running several years. The interest on such a loan is incurred over the period of the loan. Under the accrual method of accounting, the interest cost incurred in each reporting period is an allowable cost in the applicable reporting period.

If, under the terms of the loan, the interest is deducted when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as cost in the periods over which the loan extends.

212. Interest on Bonds

A bond is an instrument used by both corporations and government entities to borrow funds, usually for long-term capital requirements. A bond is evidence of a liability and bondholders are assured of repayment at some future dates. The terms of the bond are stated in the bond indenture and interest is usually stated as a fixed rate payable in periodic payments such as semi-annually. Interest on bonds is an allowable cost in accordance with the terms of the bond indenture, to the extent that the interest relates to bond proceeds used either to acquire assets for use in patient care activities or to provide funds for operations related to patient care.

212.1 Bond Discount and Expenses

Where bonds are sold at a price below par of face value, the difference between par and selling price represents the amount of discount. Bond discount is, in effect, an adjustment of the interest rate, a premium which the issuing company allows to the purchaser to induce him to buy the bonds at the interest rate stated for the bonds. The discount is considered to be additional interest expense paid in advance and, therefore, is includable in allowable cost. The discount, together with any expense related to the issue, is amortized over the period from the date of sale to the date of maturity of the bonds. Amortization may be made on the straight-line method or by the effective interest method whichever is customarily used by the provider.

Bond expense is the cost of floating a bond issue. Usually, it is made up of legal, accounting, appraisal and engineering fees, registration and printing of the bonds.

212.2 Bond Discount and Expense Treated Separately

Bond discount and expense may be recorded in the same account or in separate accounts. In either event, they are to be treated as described in Section 214.1. However, if they are recorded in one account, and not identifiable separately, the entire amount allowable in each reporting period is considered to be *interest expense* for purposes of Principle 1–11, "Allowance in Lieu of Specific Recognition of Other Costs.". In the computation of the allowance in lieu of specific recognition of other costs, interest expense is excluded. If the discount and expense are recorded in separate accounts of the provider or are separately identifiable, the bond discount allowable in the reporting period is *interest* expense; the allowable bond expense is considered as other operating costs.

For example, if a provider issues 5%, 20-year debentures in the amount of $1,000,000, and the bonds are sold at 98 with expenses of issuing of $10,000, the providers accounting records would indicate:

Cash (Dr)	$970,000	
Unamortized Bond Expenses (Dr)	$ 10,000	
Unamortized Bond Discount (Dr)	$ 20,000	
Bonds Payable (Cr)		$1,000,000
Annual Allowable Costs would be:		
Bond Interest (5% of $1,000,000)	$ 50,000	
*Amortized Bond Discount (1/20 of $20,000)	$ 1,000	
Total Interest Costs	$ 51,000	
*Amortized Bond Expenses (1/20 of $10,000)	$ 500	
Total Allowable Costs	$ 51,500	

*If the bond discount and bond expenses were not separately identifiable, for purposes of applying the allowance in lieu of specific recognition of other costs, the total interest cost would be considered as $51,500. If stated separately the total interest cost is $51,000.

214. Bond Premium

Where bonds are sold at a price above face value, the difference between the face value and the selling price represents the amount of bond premium. It is paid by the buyer of the bonds to the selling organization and is actually an adjustment of the total interest expense which is realized when the bonds are sold. The amortized portion of bond premium is a reduction of allowable costs.

214.1 Bond Premium Recorded Separately

Bond premium should be recorded as a deferred credit, and amortized proportionately over the life of the bonds. The portion applicable to each reporting period is a reduction of allowable interest costs for the reporting period. Bond premium should be recorded separately from bond expenses related to the issuance of bonds. Where bond premium and bond expenses are not separately recorded and identifiable, they are in effect netted and the entire amount allocable to the reporting period is considered as bond expenses, and thus interest expense is not reduced for purposes of computing the allowance in lieu of specific recognition of other costs under Principle 1–11.

For example, if a provider issues 5%, 20-year debentures in the amount of $1,000,000 and the bonds are sold at 102 with expenses of issuing of $10,000, the provider's accounting records would indicate:

Cash (Dr)	$1,010,000	
Unamortized Bond Expenses (Dr)	$ 10,000	
Bond Payable (Cr)		$1,000,000
Unamortized Bond Premium (Cr)		$ 20,000
Annual Allowable Costs would be:		
Bond Interest (5% of $1,000,000)	$ 50,000	
*Less Amortized Bond Premium (1/20 of $20,000)	$ 1,000	
Total Interest Costs	$ 49,000	
*Amortized Bond Expenses (1/20 of $10,000)	$ 500	
Total Allowable Costs	$ 49,500	

*In this example, the bond premium and bond expenses are recorded separately and identifiable. If they were not separately identifiable, for purposes of Principle 1–11, the total interest cost would be considered as $50,000. If stated separately the total interest cost is $49,000.

216. Government Bond Issues

Many providers, particularly hospitals, are owned and operated by Federal, State, and local governments. The facilities are constructed or acquired with funds raised by the governmental entity. Governments at all levels, of course, raise funds for operating and capital expenditures by levying taxes and by borrowing through the device of issuing bonds.

216.1 Government Bond Issues for Construction

Some governmental facilities are constructed or

acquired with funds obtained from bond issues *specifically designated* for the construction or acquisition of the facilities. Most of these bond issues are designed to meet the construction costs of more than one facility. In such cases, a proportionate part of the interest payable on the bonds is applicable to the provider and is an allowable cost. If the bond issue is designated for construction of only the provider's facilities, all of the interest expense applicable to the bond issue is allowable.

216.2 General Purpose Government Bond Issues

In some cases, the funds used to construct or acquire the governmental facilities are obtained from the general purpose funds of the government-owner. Even though a portion of such fund is raised through bond issues no part of the interest payable on the bonds is allowable as a cost of the provider.

218. Interest on Loans from Lenders Related to the Provider

One of the elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. (See Chapter 10 for the definition of control and ownership.) Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement for higher rates of interest or for unnecessary loans. This provision is intended to assure that loans are legitimate and needed, and that the interest rate is reasonable. An exception to this general rule is contained in Sections 218.2 and 220.

218.1 Interest Paid to Partners, Stockholders, and Related Organizations

Generally, interest paid by the provider to partners (owners), stockholders, or related organizations of the provider is not allowable as a cost. Where the owner uses his own funds in a business, the funds are considered invested funds or capital, rather than borrowed funds. Therefore, when a partner, stockholder, or related organization makes a loan to a provider, and the interest on the loan is not allowable as a cost, the loan is considered as part of the equity capital of the provider. (See Chapter 12, "Return on Equity Capital," Section 1220.3(e).)

218.2 Interest Paid to Partners, Stockholders, and Related Organizations on Loans Made Prior to July 1, 1966

There is an exception to the general rule stated in Section 218.1. It applies where interest is paid to a partner (owner), stockholder, or related organization on loans made before July 1, 1966, provided that the terms and conditions of payment of such loans have been maintained in effect without modification after June 30, 1966. Interest on such loans made before July 1, 1966, is allowable as a cost.

218.3 Owner(s) of Provider Institution on the Board of Directors of Lending Institution

Owners of providers may sometimes serve as members of the Board of Directors of a bank or other financial institution which lends money to the provider. A determination as to whether a personal relationship or control exists between the provider and lending institution within the meaning of Section 218 will be based on the facts and circumstances of each case.

220. Interest Paid to the Mother House or Other Governing Body of a Religious Order

Providers owned and operated by members of religious orders often obtain funds through loans from the Mother House or Governing Body of the religious order. Where there is a contractual agreement for the payment of interest, and for the eventual repayment of the loan, the interest expense is allowable as cost provided the interest is applicable to the period after the certification of the institution as a provider. Interest expense incurred during a reporting period must be *paid* within the succeeding reporting period.

222. Provider's Unrestricted Funds

Frequently a provider receives gifts and grants to be used for any purpose management determines to be appropriate. These gifts and grants are unrestricted in that the donor has not indicated a particular use to which the donation must be applied. Sometimes, the provider does not use these funds immediately. In such cases, the monies may be "funded," or placed in a physically segregated account, and retained until the provider decides to use them, or they may be recorded in the accounting records designating gifts and grants and the cash deposited with the general funds of the provider.

222.1 Interest Paid to Unrestricted Funds

Where unrestricted funds are used to make "loans" to the general funds of the provider for use in current operations, or for other purposes, interest paid by the general fund to the unrestricted fund is *not allowable* as a cost. Unrestricted funds are available for the use of the provider, and the provider should use them rather than "borrow" them. The same treatment applies to funds created by the provider's restricting its own funds for particular management purposes.

222.2 Interest or Other Income Earned by Unrestricted Funds

Where the provider has invested funds from gifts or grants which are unrestricted as to use, and these funds are commingled with other funds, the provider's allowable interest expense is reduced by the amount of the investment income earned by the fund.

However, if the gifts and grants are not *commingled* with other funds, the investment income earned by the fund does *not* reduce allowable interest expense. "Not commingled" means held physically separate, as deposited in a different bank account from the general funds. The separation of these funds provides identification of both the fund and related income.

222.3 Withdrawals from Unrestricted Funds

An unrestricted fund may contain deposits from gifts and grants and added deposits of general funds reserved for a future use by management. In this case, withdrawals from the fund are considered made from the added deposits of general funds until such funds are exhausted. Income earned by the added deposit of general funds will be applied as a reduction of interest expense.

224. Provider's Restricted Funds

Providers sometimes receive a gift or grant from a donor who specifies that it is to be used for a *specific purpose.* When a provider accepts such restricted funds from a donor, a trustee relationship is established wherein the provider is acting as a trustee for the donor in regard to the funds donated and tht provider is bound by the conditions set forth by the donor. This is a "restricted" gift or grant and must be used for the designated purpose. (See Section 602.) Where the proceeds of a donor-restricted grant or gift are placed in a fund to be retained until it may be used, the fund is known as a restricted fund.

224.1 Interest Paid to Restricted Funds

Where a provider's donor-restricted funds make loans to the general fund of the provider, the interest paid by the general fund to the restricted fund is an allowable cost. Since these funds are not available for use by the provider except as designated, it is expected that the provider would invest them until they are used. For this reason, interest is allowable if the funds are loaned to the general fund.

If these funds are borrowed for construction purposes, the interest earned by the funds would not be applied as a reduction of interest expense; the interest paid to the fund during the period of construction is capitalized as part of the cost of construction and recovered as allowable depreciation.

224.2 Interest or Other Income Earned by Restricted Funds

Where the provider has invested donor-restricted funds and these funds are not commingled with other funds, the investment income from such funds does *not* reduce the allowable interest expense of the provider.

If restricted funds are commingled with the provider's other funds, the investment income earned on the fund does reduce allowable interest expense. In a common fund, restricted funds lose their identity and all earnings are applied as a reduction of allowable interest expense.

224.3 Withdrawals from a Restricted Fund

A donor-restricted fund might contain added deposits made from the general funds of the provider, or from other unrestricted funds. In this case, withdrawals from the fund for other than the specified purposes of the restricted fund are considered to be made first from the added deposits until such deposits are exhausted. These added deposits are considered as *unrestricted funds.* Also, unless the donor specifically provides that earnings applicable to restricted funds may be used for a designated purpose, interest expense must be reduced by such earnings.

226. Funded Depreciation

Funding of depreciation is the practice of setting aside cash, or other liquid assets, in a fund separate from the general funds of the provider to be used for replacement of the assets depreciated, or for other capital purposes. The deposits to the fund are generally in an amount equal to the depreciation expense charged into costs each year, and are in effect made from the cash generated in excess of cash expenses by the non-cash expense depreciation.

Funding of depreciation by a provider may be required under the terms of a bond indenture, mortgage, or other lending agreement, in which the creditors restrict the use of such funds by the providers. In these situations, a trustee relationship is established by contract or agreement, wherein the provider is acting as a trustee in regard to the amounts required to be funded and the use of such funds as stipulated in the agreement.

A provider also may place self-imposed restrictions on the use of funds received equivalent to the depreciation expense for each period and voluntarily fund depreciation. The action to fund depreciation voluntarily would ordinarily be made by the appropriate managing body of the provider, such as the Board of Trustees or Board of Directors, in accordance with the needs and objectives of management. As such needs and objectives change, appropriate action could be taken by the managing body to use all or part of the funds in the funded depreciation account for purposes other than originally intended. Specific provisions of this chapter are applicable to situations where deposits to the funded depreciation account are used for purposes other than originally intended.

Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies.

226.1 Interest Paid on Loans from Funded Depreciation

When the general fund of the provider borrows from the *funded depreciation*, interest paid by the general fund to the funded depreciation account is an allowable cost. The requirements of necessary and proper apply to such loans.

226.2 Interest or Other Income Earned by the Funded Depreciation Account

Where the provider funds depreciation, it is expected that the money in the fund will be invested to earn revenues. Investment income earned by the funded depreciation account is *not* a reduction of allowable interest expense. This provision should be an incentive for the funding of depreciation.

226.3 Deposits in the Funded Depreciation Account

The provider may deposit in this account the cumulative *allowable* depreciation expense, in part or in the entire amount, applicable to its period under the Medicare program. Allowable depreciation is the total amount of depreciation from date of acquisition and is either the total accumulated depreciation recorded in the provider's accounting records or the total accumulated depreciation calculated in accordance with Chapter 1, "Depreciation," Section 114. Further, from time to time, the provider may make "extra" deposits of funds in excess of the accumulated depreciation under the program. Where deposits represent allowable depreciation, or the investment income earned thereon, the provisions of 226.1 and 226.2 apply; where deposits are in excess of the allowable depreciation, the provisions of sections 226.1 and 226.2 do not apply. Any income earned by such extra funds is applied as a reduction of interest expense.

Deposits representing depreciation must be in the funded depreciation account for *6 months or more* to be considered as valid funding transactions and to permit application of sections 226.1 and 226.2. Deposits of less than 6 months duration are not eligible for the benefits of those sections. However, if such deposits representing depreciation are invested at any time before the 6 month period has elapsed, and remain as invested funds beyond the 6 month period, the investment income for the entire period will be treated as provided in 226.2 and will be considered as valid fund transactions.

226.4 Withdrawals from the Funded Depreciation Account

Since deposits in the funded depreciation account may consist of a variety of funds, and to assure that the incentives provided under the program are applied to valid funding transactions, the following sequence of withdrawals will be recognized under the program.

Withdrawals for the acquisition of additional capital assets, including the payment of mortgage principal on these assets, and for investment purposes are made on a first-in, first-out basis. The oldest deposits will be withdrawn first.

Withdrawals for general operating purposes or to make loans to the general funds are made on a last-in, first-out basis. The latest deposit made will be considered the deposit withdrawn for these purposes. For example, if a loan is made to the general fund on February 1, and deposit of the same or greater amount is in the funded account since January 1, the withdrawal will be considered to be made from

the January 1 deposit and interest if any paid by the general fund is *not* allowable as a cost.

Funded depreciation or other deposits in the funded depreciation account may be used by the provider for purposes other than the improvement, replacement, or expansion of facilities or equipment related to patient care. In such cases, allowable interest expense in the period of withdrawal is reduced to adjust for offsets not made in prior years for earnings applicable to such funds. For example, if the provider withdraws funds equal to two years' deposits, using the last-in-first-out method, any earnings applicable to these deposits during the two year period are applied as a reduction of interest expense incurred during the period of withdrawal.

226.5 Money Borrowed to Fund Depreciation

When a provider borrows money to make deposits of funded depreciation, interest paid by the provider on the money borrowed for this purpose is not allowable as cost.

228. Qualified Pension Fund

Generally, a qualified pension plan under Internal Revenue Service regulations is a plan established and maintained by a provider primarily to provide systematically for the payment of definitely determinable benefits to the provider's employees for a period, usually for life, after retirement. The trust instrument establishing the plan would provide for a fund to be accumulated by the trust in accordance with the plan. Deposits of cash or other liquid assets are made to the fund in accordance with the pension plan. In the establishment of such pension funds, a trustee relationship is created with the provider in regard to the deposits into the fund and their use in accordance with the pension plan. The same treatment accorded to deposits of funded depreciation are accorded deposits in the qualified pension fund. (See Sections 226 to 226.5)

230. Interest Expense of Related Organizations

Where a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as a cost, costs of ownership of the leased facility are allowable costs of the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider. (Chapter 10, "Cost to Related Organizations," Section 1008.)

232. Effect of Current Financing Payments

Allowable interest expense on current indebtedness of a provider will be adjusted to accommodate the effect of current financing payments to the provider. This adjustment will reflect the extent to which working capital needs attributable to covered services for beneficiaries have been met by payments to the provider designed to reimburse the provider currently as services are furnished to beneficiaries.

For example, assume the following:

1. Working capital borrowed by Provider	$40,000
2. Current financing payments under Medicare	10,000
3. Total working capital "Borrowed"	$50,000
4. Percentage of allowable cost applicable to Medicare	25%
5. Working capital needed for covered services	$12,500
6. Borrowed funds on which interest would be allowable (line 5 less line 2)÷25%	$10,000

Chapter 12

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

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Chapter 12

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

1200. Principle

An allowance of a reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period, or portion thereof covered under the program.

1202. Definitions

1202.1 Equity Capital

Equity capital means (1) the provider's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds), and (2) net working capital maintained for necessary and proper operation of patient care activities (excluding the amount of any current payment made pursuant to Chapter 24 of this manual). In effect, equity capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicare program), adjusted for those assets and liabilities which are not related to the provision of patient care.

1202.2 Plant, Property, and Equipment

The classification "plant, property, and equipment" includes all assets and liabilities not specifically classified otherwise in the definition of equity capital in Section 1202.1. Primarily, this would include fixed assets and and long-term debt, but in view of the variety of balance sheet presentations of assets and liabilities, "plant, property, and equipment" must be defined in the more inclusive manner, i.e., buildings, land, fixtures and equipment, goodwill, and other assets not part of current assets. Also, included in this category is any long-term debt not specifically related to particular items of plant, property, and equipment.

1202.3 Net Working Capital

Working capital is the difference between current assets and current liabilities. For provider reimbursement purposes, net working capital is working capital reduced by any amount determined to be excessive for the necessary and proper operation of patient care activities. (Unless specifically stated otherwise in the manual, current assets and current liabilities are determined in accordance with generally accepted accounting principles.)

1202.4 Proprietary Providers

The term "proprietary providers" means providers, whether sole proprietorships, partnerships, or corporations organized and operated with the expectation of earning profit for the owners, as distinguished from providers organized and operated on a nonprofit basis.

1204. Base for Computing Return

The base amount of equity capital to be used for computing the allowable return is the *average* investment of the owners during the reporting period. Investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other cost purposes under the health insurance program. The equity capital in each month is determined and an average of the monthly amounts computed. This is the average equity capital in use during the period. Where the period is less than a year, a proportionate amount of the return is allowable, i.e., seven month period—only 7/12ths of the return is allowable.

1206. Rate of Return

The rate of return on average equity capital is a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program. The rate of return varies as the interest rates on such issues of public debt obligations vary.

The percentage rate is determined by the Social Security Administration and communicated through the intermediaries.

1208. Deposits on Leases

Funds deposited by a provider who leases plant, property, or equipment used for patient care are includable in equity capital if the deposits are required by the terms of the lease. The deposits must be reduced by any noncurrent liabilities related to such deposited funds. Any additional deposits or reductions in deposits required under the lease are treated as additional investments or withdrawals of capital when the transactions occur.

1210. Loans from Owners

Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable as costs are not subtracted from assets in computing the owners' equity capital. Funds obtained through such loans are considered as invested capital of the provider. (See Chapter 2, Section 218 of this manual.) By not subtracting them from assets. the equity capital of the owners is increased.

The following debts representing loans from owners or related organizations are not subtracted from assets in computing equity capital:

1. Loans from owners or related organizations made after June 30, 1966.

2. Loans from owners or related organizations made before July 1, 1966, where the terms and conditions of payment *have been modified* after July 1, 1966.

3. Non-interest bearing loans, regardless of when the loan was made.

Debts representing loans from owners or related organizations made before July 1, 1966, are subtracted from assets where the terms and conditions of payment have *not* been modified subsequent to July 1, 1966.

Transferable debenture bonds issued to owners as evidence of loans are treated as though they were issued to non-owners and are subtracted in determining the provider's equity capital. However, nontransferable debenture bonds issued to the owners are treated as loans from owners in accordance with Chapter 2 of this manual.

1212. Assets Leased from Related Organizations

Generally, reimbursement to any provider leasing facilities or equipment from a "related organization" is limited to the costs of ownership of the leased facilities (depreciation, taxes, interest expenses, etc.) in accordance with Chapter 10 of this manual, just as though the provider owned the facilities. Therefore, the owners' equity in the leased assets is includable in the equity capital of a proprietary provider. (See Chapter 10, Section 1010 of this manual for an exception to this general rule.)

1214. Goodwill

Goodwill purchased in the acquisition of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles.

However, goodwill which has not been purchased but has been internally generated as, for example, from a reorganization of the provider, is not includable in the provider's equity capital.

1216. Gifts and Grants

Gifts and grants which are unrestricted as to use are includable in the provider's equity capital. (See Chapter 12, Section 1220.2g.) However, restricted gifts and grants are *not* includable in the provider's equity capital.

1218. Exclusions from Equity Capital

1218.1 Exclusions—General Rule

Assets and liabilities not related to providing patient care are not includable in the provider's equity capital. Excludable assets and liabilities not specifically treated elsewhere in this chapter are discussed in this section.

1218.2 Invested Funds

Invested funds are funds diverted to income producing activities which are not related to patient care. Any portion of the provider's general funds or operating funds invested in such activities for more than six consecutive months is not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds." Further, if the time period covered by such fund investment is interrupted by a number of withdrawals and redeposits so that the effect of such transactions is that funds are invested for more than six consecutive months, these invested funds are not included in equity capital.

1218.3 Funded Depreciation Account

Where the provider establishes an account in which amounts representing payments received, or amounts accrued, for depreciation expense are deposited, the amounts deposited in this account and the

earnings on the funded depreciation which remain in the fund are not includable in equity capital.

1218.4 Assets Held in Anticipation of Expansion

Land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets will also be excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.

1218.5 Cash Surrender Value of Life Insurance

Where a provider carries life insurance on officers and key employees, with the provider designated as the beneficiary, the cash surrender value of the policy should be shown as an asset. Any cash surrender value of such insurance is not included in equity capital.

1220. Calculation of Average Equity Capital

1220.1 General

The average equity capital of the provider is determined by adding to the balance of equity capital at the beginning of the reporting period, the month by month net changes resulting from certain specific transactions as indicated in the following sections. All elements entering into the net difference between the equity capital at the beginning of the period and the equity capital at the end of the period are accounted for in the computation. An average amount of the monthly balances in use during the period is then computed. By this method the provider is not required to maintain his records on a full accrual accounting basis at any time except at the end of the reporting year.

1220.2 Deficits or Accumulated Losses

As a result of losses in the operation of a facility, sometimes over a number of cost reporting periods, the investment of the owners may be decreased to an amount less than the original investment or may even be eliminated. These accumulated losses are usually shown as a deficit in the Retained Earnings account or other capital account of a corporation and, where proprietorships and partnerships are concerned, are reflected in the balances in the owners' capital accounts.

Such accumulated losses are reflected on the determination of equity capital as reductions of the owners' original investment. Since equity capital is, in effect, the net assets of the owners used during the period to provide patient care, where net assets are reduced for whatever reason, the owners' equity is reduced. Where a negative amount is shown in the owners' equity there, of course, is no basis for allowing a return on equity capital.

1220.3 Factors in Calculation of Average Equity Capital

a. *Equity capital at the beginning of the period*—This amount is the owners' equity in the provider's assets and liabilities related to patient care at the beginning of the cost reporting period, based on the assets and liabilities of the provider as stated under the principles of reimbursement of Medicare.

b. *Capital investments during the period*—This includes additional amounts of new capital invested by the owners in the patient care activities of the provider. Capital investments are included in the computation in the month in which they are invested. Transfers of stock between owners do not affect the capital invested.

c. *Gain or loss on sale of assets*—This includes the gain or loss on the sale of assets as determined under the provisions of Chapter 1 of this manual. Such gains or losses are included in the calculation in the month in which they are realized. Gross receipts from the sale of any asset not related to patient care (excluded from equity capital) are included in this category if they are put into the general operating funds.

d. *Withdrawals by owners*—Equity capital is reduced by withdrawals of cash or other assets by the owners. These withdrawals may be in the form of reductions of invested capital, dividend distributions, payments of personal expenses of owners from the operating funds or other funds related to patient care, or drawings of owner's salary or living expenses not reflected in the profit or loss account. Such withdrawals are included in the calculation in the month in which they are made.

e. *Loans from owners*—Loans from owners which are considered as invested capital under the provisions of Section 1210 are included in this category. Loans made are included in the calculation in the month in which they are made and repayments of loans are included in the month in which they are repaid in the "Other Increases" column.

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f. *Changes due to operations*—Equity capital increases or decreases during the reporting period when net income is earned or when net losses are incurred in operations of the provider. These net increases or decreases may result from patient care activities, including Medicare, or from activities not related to patient care which increase or decrease net patient care assets. One of these changes is the *net profit or loss* from patient care activities. Another such change results when revenue from nonpatient care activities is commingled with the operating fund and used in activities related to patient care.

The net amount of the change in equity capital from this category of transactions is determined by analyzing the difference between equity capital at the beginning of the period and the equity capital at the end of the period. From this net increase or decrease in equity capital are subtracted the amounts included under the other categories of changes on the worksheet for the computation of the return on equity capital. The remainder then will represent the increase or decrease due to operations; however, any amount for a return on equity included in the difference between the beginning and ending equity capital is excluded from this remainder. In the computation, the increase or decrease due to operations is considered as occurring uniformly during each of the months of the reporting period.

g. *Other increases*—Equity capital may be increased by gifts or grants which are unrestricted as to use. Such increases are included in the calculation in the "Other Increases" column in the month in which the gifts or grants are received. Where such gifts or grants consist of small amounts they may be included in the amount determined as the "change from operations."

h. *Equity capital at the end of the month*—Where the equity capital at the end of a month after all increases and decreases in that month have been taken into consideration is a negative amount, show a zero in column 8. The purpose of this principle is to give the owners credit for all their capital invested and used in patient care. If a negative amount is used in column 8, instead of a zero, the owner would be penalized for not having equity capital. Therefore, a zero should be inserted and used in the computation of the average.

1220.4 Examples

Following are two examples with explanatory notes of additions and subtractions which will be considered in calculating average equity capital.

Notes for Case Studies

An examination of the provider's accounting records discloses the following:

Column No. 2—Equity capital at the beginning of the period, based on the provider's balance sheet under Medicare regulations.

Case No. 1—$10,000

Case No. 2—($10,000)

(Negative Equity Capital)

All other elements are considered to be identical for both case studies.

Column No. 3—Additional investments of $5,000 each were made in July and October.

Column No. 4—A loss of $4,000 was incurred in March as a result of the sale of an asset and a gain of $6,000 was realized in August as the result of the sale of another asset.

Column No. 5—Withdrawals of $800 per month for salaries were made by the owners. These withdrawals were recorded in the owners' drawing accounts and are not included in the profit or loss computation. If these amounts withdrawn by owners as salaries were included in the computation of profit, they would not be entered here.

Column No. 6—A loan of $5,000 was made to the provider by an owner in February 1967, and repaid in July.

Column No. 7—Operating profit and other changes due to operations for the period amounted to $24,000; this does not include any amounts withdrawn by the owners as salaries. It also includes amounts representing revenues from the gift shop operated by the provider.

Column No. 8—When the elements of equity capital in each month result in a negative amount, or deficit, when combined into a total figure in column 8, a zero (0) is entered in this column and used in the average computation.

Computation of the amount of return is based on an assumed rate of 7%. This rate is used only for illustrative purposes, and is not intended to be the rate which the provider will use. The actual rate is furnished by the intermediary.

The amount of reimbursable return will be determined based on the ratio of total reimbursable costs to total allowable costs. For example, if total allowable costs are $100,000, all allocable to Medicare patients, 100% of the computed return is reimbursed. If $60,000 of the $100,000 is allocable to the program, 60% of the return is reimbursed. Where the reporting period is less than a full year, a proportionate amount of the return is allowable.

EXAMPLE NO. 1

COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Month	Equity Capital Beginning of Period	Capital Investments during Period	Gain or (loss) Sale of Assets	Withdrawals or Dividend Distribution	Other Increases or (Decreases)	Increases or Decreases Due to Operations	Equity Capital End of Month (Net total of Col. 2 thru 7)
1	2	3	4	5	6	7	8
1. January	$10,000	$ –0–	$ –0–	$(800)	$ –0–	$ 2,000	$ 11,200
2. February	10,000	–0–	–0–	(1,600)	5,000	4,000	17,400
3. March	10,000	–0–	(4,000)	(2,400)	5,000	6,000	14,600
4. April	10,000	–0–	(4,000)	(3,200)	5,000	8,000	15,800
5. May	10,000	–0–	(4,000)	(4,000)	5,000	10,000	17,000
6. June	10,000	–0–	(4,000)	(4,800)	5,000	12,000	18,200
7. July	10,000	5,000	(4,000)	(5,600)	–0–	14,000	19,400
8. August	10,000	5,000	2,000	(6,400)	–0–	16,000	26,600
9. September	10,000	5,000	2,000	(7,200)	–0–	18,000	27,800
10. October	10,000	10,000	2,000	(8,000)	–0–	20,000	34,000
11. November	10,000	10,000	2,000	(8,800)	–0–	22,000	35,200
12. December	10,000	10,000	2,000	(9,600)	–0–	24,000	36,400 (a)
13. Total							$273,600

(a) The provider's year-end balance sheet, under medicare regulations, must reflect this amount as owner's equity.

14. Total Dollars (from Col. 8, Line 13)		Number of Months in Reporting Period		Average Equity Capital During the Period		Rate of Return		Amount of Return for Twelve Month Period
$273,600	÷	12	=	$22,800	×	7.000%	=	$1,596

15. Amount allowable for current period (1/12 of line 14 for each month in the current reporting period) $ *

*Do not use line 15 if reporting period is full year.

EXAMPLE NO. 2
COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Month	Equity Capital Beginning of Period	Capital Investments during Period	Gain or (loss) Sale of Assets	Withdrawals or Dividend Distribution	Other Increases or (Decreases)	Increases or (Decreases) Due to Operations	Equity Capital End of Month (Net total of Col. 2 thru 7
1	2	3	4	5	6	7	8
1. January	$(10,000)*	$ –0–	$ –0–	$(800)	$ –0–	$ 2,000	$ –0–
2. February	(10,000)	–0–	–0–	(1,600)	5,000	4,000	–0–
3. March	(10,000)	–0–	(4,000)	(2,400)	5,000	6,000	–0–
4. April	(10,000)	–0–	(4,000)	(3,200)	5,000	8,000	–0–
5. May	(10,000)	–0–	(4,000)	(4,000)	5,000	10,000	–0–
6. June	(10,000)	–0–	(4,000)	(4,800)	5,000	12,000	–0–
7. July	(10,000)	5,000	(4,000)	(5,600)	–0–	14,000	–0–
8. August	(10,000)	5,000	2,000	(6,400)	–0–	16,000	6,600
9. September	(10,000)	5,000	2,000	(7,200)	–0–	18,000	7,800
10. October	(10,000)	10,000	2,000	(8,000)	–0–	20,000	14,000
11. November	(10,000)	10,000	2,000	(8,800)	–0–	22,000	15,200
12. December	(10,000)	10,000	2,000	(9,600)	–0–	24,000	16,400 (a)
13. Total							$60,000

*Indicates Negative Equity Capital. (a) See example No. 1, Note (a)

14. Total Dollars (From Col. 8, line 13)		Number of Months Reporting Period		Average Equity Capital During the Period		Rate of Return		Amount of Return for Twelve Month Period
$60,000	÷	12	=	$5,000	×	7.000%	=	$350

15. Amount allowable for current period (1/2 of line 14 for each month in the current reporting period $ *

*Do not use line 15 if reporting period is full year.

Chapter 23

Adequate Cost Data and Cost Finding

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Chapter 23

Adequate Cost Data and Cost Finding

2300. PRINCIPLE

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

2302. DEFINITIONS

2302.1 Accrual Basis of Accounting—Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

2302.2 Cash Basis of Accounting—Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

2302.3 Governmental Institutions—A provider of services in which the facility is owned and operated by either a Federal, State, or Local governmental agency.

2302.4 Allocable Costs—An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

2302.5 Applicable Credits—Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the Federal Government to finance hospital activities or service operations should be treated as applicable credits.

2302.6 Charges—Charges refers to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

2302.7 Cost Finding—A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

2302.8 Cost Center—A division, a department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

2302.9 General Service Cost Centers—Those divisions, departments or subdivisions thereof, etc., which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

2302.10 Special Service Cost Centers—Commonly referred to as Ancillary Cost Centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the operating room, radiology, laboratory, etc.

2302.11 Inpatient Cost Centers—Cost centers established to accumulate costs applicable to providing routine and ancillary services of inpatients for the purposes of cost assignment and allocation.

2302.12 Outpatient Cost Centers—Cost centers established to accumulate cost applicable to the care and treatment of outpatients.

2302.13 Outpatient Occasions of Service—Each examination, consultation or treatment received by an outpatient in any service department of a hospital. Such occasions of service should be recorded by individual departments and classified as to emergency room, clinics or private ambulatory.

2302.14 Private Ambulatory — Patients referred to the provider by their private physicians to receive treatment or diagnostic tests in one or more of the ancillary cost centers (special service cost centers) and who do not receive any services in the clinic or the emergency room. Such patients are sometimes referred to as Private Referred Outpatients or Private Outpatients.

2302.15 RCC—The ratio of charges to charges. The bases, or charges, used in the RCC formula varies as to the costs to be allocated. The ratios may be expressed as follows:

a. ratio of beneficiary charges to total charges on a departmental basis. See illustrations in Chapter 22.

b. ratio of beneficiary charges for ancillary services to total charges for ancillary services. See illustrations in Chapter 22.

c. ratio of total patient charges by patient care centers to the total charges of all patient care centers. See Exhibit I–9 of this chapter for an example.

2302.16 Overhead — In the procedures outlined in this chapter, overhead rates are not developed except where such rates are used in the computation of cost per visit used in connection with the National League for Nursing, Method II. In this connection, overhead cost is the total expense of the agency, minus the costs accounted for in nursing services, supervision, transportation and expenses normally considered as indirect cost but chargeable to a direct service through allocation.

2302.17 Home Health Discipline—A branch of learning such as medicine, nursing, physical therapy, etc., each of which requires special skills and training. In cost finding for home health agencies, it is desirable to develop separate visit costs for services provided by the various disciplines. For example, separate visit costs should be developed for nursing, physical therapy, occupational therapy, speech therapy, etc., rather than an overall average visit cost.

2302.18 Home Health Visit—A personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for the furnishing of a covered service on an outpatient basis because it requires the use of equipment which cannot be made readily available in the home.

2304. ADEQUACY OF COST INFORMATION

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made to the intermediary.

2306. COST FINDING METHODS

After the close of the reporting period, one of the following methods of cost finding should be used to determine the actual costs of services rendered during that period.

2306.1 Step-down Method—This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first. Exhibit I illustrates this method.

2306.2 The Double-Apportionment Method—The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers. This method is illustrated in Exhibit II.

2308. COST FINDING METHODS—HOME HEALTH AGENCIES

2308.1 National League for Nursing—Method I—This method separates the home visiting costs from the other nursing services and activities referred to as non-visiting costs, such as clinics, classes, work in school, etc. After deducting non-visiting costs, visiting costs are divided by the total number of home visits to obtain the cost per visit for the reporting period. An acceptable variation of this method is the determination of a separate rate for nursing and a separate rate for home health aides. This method is illustrated in Exhibit IV. For further details of NLN Method I refer to "NLN Cost Analysis for Public Health Nursing Services," Code 21–1159, issued 1964 by the National League for Nursing, Department of Public Health Nursing.

2308.2 National League for Nursing Method I—Revised 1967—Under this method the cost of a specific type of visit is determined, such as physical therapy, speech therapy, or home health aide service visits. It also provides that the cost of skilled nursing visits be refined to differentiate between the cost of a visit for the care of the sick or diseased from the cost of a visit made in the interest of disease prevention or health promotion, based upon a time study. Until Form SSA–1728 is revised, the home health agency may substitute its own worksheets and schedules for Schedule A–3 through A–10. Further details regarding this method may be found in the publication of the Department of Public Health Nursing, National League for Nursing, Inc., Code 21–1267, issued 1967.

2308.3 National League for Nursing—Method II—This is a refinement of the average cost per visit method and may be adapted to obtain costs of many separate activities or services, such as various classification of visits to individuals. The overall cost per visit or the visit cost for each discipline providing the service such as nurse, physical therapist, home health aide, etc., may be determined. Exhibit V illustrates this method. For further details of NLN Method II refer to "NLN Cost Analysis for Public Health Nursing Services," Code 21–1159 issued 1964 by the National League for Nursing, Department of Public Health Nursing.

2308.4 Combined PHS-NLN Method — This procedure finds the cost of a visit by developing the time per work unit through time study and allocation of unidentified costs based upon a ratio of these unidentified costs to total costs excluding salaries.

The following procedures are necessary to determine the cost of each work unit of service:

a. The collection, during a sufficient sample period, usually a month, of data on the amount of time spent on selected units of work.

b. A summary of the time spent by all staff members.

c. A summary of the number of work units performed during the same calendar month as the time study and during the reporting year.

d. Calculation of direct costs and an allocation of the unidentified costs to total costs excluding salaries.

e. The costs for services are then distributed based upon the same proportion as the time spent on the direct service work unit.

For further details on the combined PHS–NLN Method procedure for cost allocation refer to "How to Determine Nursing Expenditures in Small Health Agencies" by Marion Ferguson, R.N., Ph.D., Public Health Service Publication No. 902, revised 1966. This method is illustrated in Exhibit VI.

2310. MORE SOPHISTICATED METHODS

A more sophisticated method designed to allocate cost more accurately may be used by the provider upon approval of the intermediary.

2312. CONSISTENCY OF METHODS

Having elected to use a certain method of cost finding, the provider may not thereafter use another method without approval of the intermediary. A request in writing for such approval must be made on a prospective basis and must be submitted before the end of the fourth month of the reporting period in which the change will be effected. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use a less sophisticated method without similar request and approval.

2320. COST FINDING SCHEDULES

2320.1 General Comments—The cost data submitted must be based on the accrual basis of acounting which is recognized as the most accurate basis for determining costs. Particular attention should be given to accruals in the first reporting period, particularly if the first reporting period is a short period. All accruals of a significant nature must be recorded on the provider records at year end to preclude inequity of cost allocation. Those providers who maintain their records on a cash basis may record such accruals as worksheet adjustments. Significant costs to be represented by accruals include, but are not limited to: employee vacation pay, bonuses, and professional fees. Governmental institutions that operate on a cash basis of accounting may submit cost data on that basis subject to appropriate treatment of capital expenditures. Cents are omitted in the preparation of all worksheets and schedules except when inclusion is required to properly reflect average per diem cost, average cost per visit, average cost per hour, etc. Percentages should be carried 2 places to the right of the decimal point except where different instructions for percentages are specified in home health agency cost forms. Bases other than those recommended for any of the following schedules may be used with the intermediary's approval provided such bases will produce more accurate results. In lieu of the forms provided, the provider may wish to use its own worksheets and schedules. These are acceptable if the information and data are presented in a manner comparable to the required forms and are approved by the intermediary. Cost reports are due on or before the last day of the third month following the close of the accounting period.

2322. FORM SSA–1562 REIMBURSABLE COST ON THE DEPARTMENTAL RCC METHOD OR COMBINATION METHOD (COMPUTED WITH COST FINDING)

This form provides for determining reimbursement using cost finding for hospitals and incorporates the following schedules:

Schedule A. Reclassification of Trial Balance of Expense

Schedule B. Cost Apportionment—General Services

Schedule C. Departmental Cost Apportionment

Schedule D. Cost Per Unit of Service

See §§ 2322.1 to 2322.13 inclusive for explanations of schedules included in Form SSA–1562. For further explanation of calculations and procedures see "Cost Finding for Hospitals" (1957) by the American Hospital Association.

2322.1 SSA–1562 Schedule A—Reclassification of Trial Balance of Expenses—This schedule provides for listing the trial balance of direct expenses as shown by the hospital's general books as follows:

a. Column 1—Salaries

b. Column 2—Other Expenses

c. Column 3—Total Expenses

Column 4 provides for the reclassification of data appearing in Columns 1, 2 and 3 for the purpose of effecting proper cost distribution. Schedules A–1, A–2, A–3 and A–4 support such reclassifications.

Column 5 reflects adjustments to expenses made on Schedule A–5.

Column 6 represents the adjusted expenses to be entered on Worksheet B and apportioned to the patient care costs centers involved. Also, in this column, enter on line 35 the 2% allowance as computed on Form SSA–1563A. This allowance should be combined with administrative and general expense upon transfer to Worksheet B. See § 2322.16 of this chapter for further instructions.

When salaries (Column 1) are used as the base for distributing costs on Worksheet B, such salaries should reflect the reclassifications made on Schedule A–1 through Schedule A–5.

2322.2 SSA–1562 Schedule A–1—Administrative and General Expense Analysis—This schedule provides for separating employee health and welfare benefits from administrative and general expenses. Administrative and general expenses are reduced by the amount of employee health and welfare benefits

and increased by the amount of interest expense where appropriate. The allowance in lieu of specific recognition of other costs should not be shown on Schedule A–1 but should be combined with administrative and general expense when these amounts are transferred from Schedule A to Worksheet B.

2322.3 SSA–1562 Schedule A–2—Dietary Expense Analysis—The purpose of this analysis is to reclassify direct costs of food, and its preparation and handling into the proper cost centers for subsequent allocation to the using departments.

2322.4 SSA–1562 Schedule A–3—Medical-Surgical Expense Analysis—This analysis reclassifies medical and surgical expenses into their proper cost centers for subsequent allocation to using departments.

2322.5 SSA–1562 Schedule A–4—Laboratory Expense Analysis—This analysis serves to segregate costs of the blood bank from other laboratory expenses in order to properly allocate such costs to the departments receiving this service. This analysis is also used where appropriate to segregate costs of Clinical Laboratory from the costs of Pathology Laboratory.

2322.6 SSA–1562 Schedule A–5—Adjustments to Expenses—This schedule reflects adjustments to total patient expenses and supports entries made in column 5, Schedule A, Form SSA–1562. Such adjustments are represented by:

a. Revenues which are actually reductions of expense rather than income (except grants or gifts applicable to specific expenses as discussed in § 2328).

b. Allowable expense not recorded on the provider's general books of account.

c. Expenses which are specifically unallowable except for such expenses to which significant general service costs apply which should be handled as indicated in § 2328.

d. That portion of provider-based physician compensation including fringe benefits not considered to be administrative expense.

2322.7 SSA–1562 Worksheet B—Cost Apportionment—General Services—This schedule employs the use of the step-down method described in "Cost Finding for Hospitals" (1957) by the American Hospital Association. Its accuracy is essential to the validity of final cost determinations and to the determination of the program's share of such costs. Its accuracy is primarily dependent on the propriety of the bases (square feet, hours of service, etc.) used to allocate costs of each department to the department(s) which receive services.

2322.8 SSA–1562 Worksheet B–1—Cost Apportionment—Statistical Basis—This worksheet is used to indicate the basis which will be applied to each cost center and is the basic starting point for allocation of costs of general service departments to other general service departments and to special service departments. The bases shown on the schedule are suggested bases. Other bases which result in a more equitable allocation may be used providing the Intermediary has approved their use. The provider must maintain adequate documentation to support the bases used.

2322.9 SSA–1562 Worksheet B1–1—Apportionment Dietary Raw Food—This schedule provides a basis for the distribution of the costs of raw food to those cost centers which received the benefits. The weighting factor gives effect to differences in the meals served patients and personnel of the respective cost centers.

2322.10 SSA–1562 Worksheet B1–2—Apportionment Dietary—Others—This schedule provides a basis for the distribution of the costs of food preparation and dietary administration costs. Part A of this worksheet provides for the direct apportionment of those other dietary costs which pertain to the cafeteria. Part B provides for the distribution of the balance of dietary costs or if Part A is not necessary the total of the dietary other costs.

2322.11 SSA–1562 Schedule C—Departmental Cost Allocation—After all costs have been stepped down to the departments within the Special Service, Inpatient and Outpatient Cost Centers and Unallowable Cost Centers, they are then allocated on this schedule to the major revenue-producing centers on the basis of:

a. RCCAC—The ratio of charges to charges applied to cost

b. Occasions of service

c. Other basis

In selecting a basis, uniformity and consistency must be observed. For example, if the ratio of charges to charges method is selected and in the absence of permission granted by the intermediary to do otherwise: (a) this method must be used for all cost centers; and (b) used in cost reports for subsequent years.

2322.12 SSA–1562 Schedule C–1—Departmental Cost Allocation—Total Gross Charges to Charges Basis—This schedule determines the ratio of

department charges by type of patient (inpatient, outpatient, etc.) to total departmental gross charges (all patients). The percentages so developed are applied to the accumulated costs on Schedule C to arrive at the distribution of costs between major revenue-producing centers. If any basis, other than RCC, is used for determining the percentages, a separate schedule should be attached to substantiate the distribution.

2322.13 SSA–1562 Schedule D—Cost Per Unit of Service—This schedule provides for determining the average cost for each unit of service. The suggested units of measure should be used wherever possible. If units other than those indicated are used, the change should be indicated where appropriate.

2322.14 SSA–1563 Depreciation Questionnaire (page 9)—This questionnaire provides information which will assist the intermediary in its review of the provider's cost report and must be submitted regardless of which cost report form the provider uses.

2322.15 SSA–1563 Computation of Optional Allowance for Depreciation (page 10)—For all depreciable assets acquired before January 1, 1966, the provider, at its option, may at the time it enters the program choose an allowance for depreciation based on a percentage of operating costs. This option is available to any provider, regardless of whether or not the provider has historical cost records of these assets. However, a provider that has elected to use actual depreciation cannot at a later date switch to the optional allowance.

The gross allowance from line 13 of this form is entered on line 22, Schedule A–5, Form SSA–1562 (see Chapter 1 §§ 124 and 126 for limitations and examples of computations).

23322.16 SSA–1563A Non-Proprietary Providers' Worksheet for Computing Allowance in Lieu of Specific Recognition of Other Costs—This form provides for the computation of non-proprietary providers' allowance in lieu of specific recognition of other costs which is entered on Form SSA–1562 Schedule A, line 35. Upon determining allowable cost it is necessary to deduct interest expenses before applying the 2% allowance. This form may also be used for proprietary providers except that the applicable percentage is 1½% in stead of 2% and the allowable cost must be reduced by both interest expense and the return on equity capital.

2322.17 SSA–1564 "Combination Method (Estimated Percentage Basis)" and SSA–1564A "Gross RCC Method"—These methods provide for separating allowable direct departmental expenses of the hospital between inpatient and outpatient (see § 2328) on some logical bases. Suggested bases for allocating revenue-producing center costs could be "Occasions of Services" as shown in the text "Uniform Hospital Definitions"—American Hospital Association. General Service department costs may be allocated to revenue-producing department direct expenses as illustrated in Exhibit III–2. Other bases used by the hospital will be acceptable, if they are approved by the intermediary as more appropriate, and will produce more accurate results. When total allowable expenses have been segregated according to type for purposes of the "Estimated Percentage Basis" estimated percentages (determined by the intermediary in conjunction with the provider) are applied to the total inpatient expenses to determine the cost of routine inpatient services and the cost of ancillary services.

The trial balance should be taken from the provider's regular accounts and should provide as much detail as is necessary.

These forms provide for the computation of allowance in lieu of specific recognition of other costs at 2% for non-proprietary providers. If a proprietary institution, then 1½% must be used.

2322.18 SSA–1564 and SSA–1564A—Adjustments to Expenses—(see § 2322.6)

2324. COST FINDING SCHEDULES—EXTENDED CARE FACILITIES

2324.1 Form SSA–1751 Reimbursable Cost on the Departmental RCCAC Method or Combination Method—(Computed with Cost Finding)—This form provides cost finding for Extended Care Facilities using the following schedules:

A. Reclassification of Trial Balance of Expenses
B. Cost Apportionment—General Services
C. Departmental Cost Apportionment

Details of these schedules are included in § § 2324.2 through 2324.8 below. Explanation of the cost finding technique is available in "Cost Finding for Hospitals (1957) by the American Hospital Association.

2324.2 SSA–1751 Schedule A—Reclassification of Trial Balance of Expenses—The trial balance should be taken from the provider's regular

accounts and segregated to show salaries and other expenses. It should be noted that whenever the salaries and other expenses are used as the base for distributing costs in other parts of this series of worksheets and schedules, consideration must be given to the salaries and wages that may have been reclassified in column 6 or adjusted in column 5 and therefore will have an impact on the distribution pattern. It may be necessary in certain cases to analyze ledger accounts in order to adjust the classification of the expense. The adjustment to expenses (from Schedule A–1) covering the sales of various services and other credits to specific expense accounts must be entered to determine the net expense for cost apportionment. The total net expenses for cost apportionment less interest is the basis for computing the allowance in lieu of specific recognition of other costs (see lines 34 through 36 of schedule). This allowance should be combined with administrative and general expense when the amounts are transferred from Schedule A to Worksheet B.

2324.3 SSA–1751 Schedule A–1—Adjustments to Expenses—This schedule reflects adjustments to total patient expenses and supports entries made in column 4, Schedule A. Refer to § 2322.2 for the types of adjustments which are to be shown on this schedule.

2324.4 SSA–1751 Schedule A–2—Administrative and General Expense Analysis—The purpose of this schedule is to provide for reclassifying amounts attributable to employee health and welfare which are included in administrative and general expense. It also provides for the addition to administrative and general expense of interest expense, utilization review costs other than physician compensation, and the allowance (1½% or 2%) in lieu of specific recognition of other costs.

2324.5 SSA–1751 Schedule A–3—Analysis of Dietary Raw Food and Dietary—Other Expense Accounts—See § 2322.4 for an explanation of the purpose of this schedule.

2324.6 SSA–1751 Worksheet B—Cost Apportionment General Services—This worksheet is intended for cost finding using the step-down method, referred to as Method II in "Cost Finding for Hospitals" (1957) by the American Hospital Association (see § 2322.7).

2324.7 SSA–1751 Worksheet B–1—Cost Apportionment Statistical Basis—See § 2322.8.

2324.8 SSA–1751 Worksheet B–2—Cost Apportionment—Dietary Raw Food—See § 2322.9.

2324.9 SSA–1751 Schedule C—Departmental Cost Apportionment Gross Charges to Charges Basis—After all costs have been allocated to Special Service, and Inpatient and Outpatient Cost Centers, the total costs of these centers are entered on Schedule C and apportioned between inpatient and outpatient services. The apportionment is made using the ratio of charges to charges applied to cost, on a statistical basis or on some other basis approved by the intermediary.

2324.10 SSA–1750 Schedule B—Depreciation Questionnaire (Part A)—This questionnaire provides information which will assist the intermediary in its review of the provider's cost report, and must be submitted regardless of which cost report form the provider uses.

2324.11 SSA–1750 Schedule B—Computation of the Optional Allowance for Depreciation (Part B)—See § 2322.15.

2324.12 SSA–1750 Schedule H—Cost Per Unit of Service—See § 2322.13.

2324.13 SSA–1752 "Combination Method (Estimated Percentage Basis)" and SSA–1753 "Gross RCCAC Method"—These methods provide for separating allowable direct departmental expenses of the facility between inpatient and outpatient (see § 2328) on some logical bases. Suggested bases for allocating revenue producing cost centers could be "Occasions of Services" as shown in the text "Uniform Hospital Definitions" by the American Hospital Association. Other bases may be used by the facility if they are approved by the intermediary as more appropriate and will produce more accurate results.

When total allowable expenses have been segregated according to type for purposes of the "Estimated Percentage Basis," an estimated percentage (determined by the intermediary in conjunction with the facility) is applied to the total inpatient expenses to separate the cost of routine inpatient services from the cost of ancillary services.

The trial balance should be prepared from the provider's regular accounts and should provide as much detail as possible. Provisions are made on these forms for computing the allowance in lieu of specific recognition of other costs and the analysis

required for the proper segregation of physicians' compensation from utilization review costs.

2324.14 SSA–1752 and SSA–1753 page 2—Adjustments to Expenses—See § 2324.2.

2326. COST FINDING SCHEDULES—HOME HEALTH AGENCIES

2326.1 SSA–1728 Home Health Agency—Statement of Reimbursable Cost—All agencies using the National League for Nursing Method I, National League for Nursing Method II, the combined Public Health Service–National League for Nursing Method or the Ratio of Medicare Charges to Total Charges Applied to Cost Method must use cost report Form SSA–1728 (7/67) to report their reimbursable costs for final settlement for the accounting period.

All agencies must complete the white section of this report consisting of pages 1 through 4 and page 9. In addition, each agency will complete one of the following sets of schedules, depending on the method used in determining costs:

a. NLN Method I (Yellow Section)
b. NLN Method II (Green Section)
c. Combined PHS–NLN Method (Blue Section)
d. RCCAC Method (Pink Section)

2326.2 SSA–1729 Hospital-Based Home Health Agency—Statement of Reimbursable Cost—Hospital-based and extended care facility-based home health agencies must develop home care costs in their step-down or other cost finding procedures by providing a separate cost center for home health care. Hospital cost report, Form SSA–1562, Schedules A through D required for hospital cost reporting should be used to determine the home health agency's direct and indirect costs. Extended care facility-based home health agencies will use the equivalent extended care facility cost report to determine the home health agency's cost. Any refinement to the above method of cost finding used for the hospital or extended care facility as a whole will be acceptable for the home health agency.

For purposes of filing the required cost report, the hospital-based home health agency will transfer the above final accumulated home health center costs to the required reporting Form SSA–1729, Schedules A–1 through A–4. Hospital-based agencies will be reimbursed on the basis of the RCCAC method.

The reporting period of the hospital-based home health agency must be the same as that of the hospital. Copies of related cost schedules filed on behalf of the hospital are to be filed with and considered as part of the cost reports of hospital-based home health agency.

Hospital-based home health agencies which do not maintain a schedule of charges will be precluded from using the RCCAC method of cost reimbursement. The hospitals falling in this category may compute home health service costs by an average cost per visit. Total Medicare visits are multiplied by the average cost per visit to arrive at total Medicare (home health) reimbursable costs. The above formula may be further refined to include an average cost per visit by each type of service.

Hospital-based home health agencies not having a uniform charge structure but using the average cost per visit method of apportionment (NLN Method I) or average cost per visit by type of service (NLN Method II or combined PHS–NLN Method) should use cost reporting Form SSA–1728.

2328. DISTRIBUTION OF GENERAL SERVICE COSTS TO NONALLOWABLE COST AREAS

Nonallowable cost centers to which general service costs apply should be entered on Worksheet B after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine "step-down" process. In the event there are more non-allowable cost centers than Schedule B can presently accommodate, then supplement schedules should be prepared. When the "step-down" process is complete, only allowable costs should be carried forward to Schedule C, Departmental Cost Allocation.

Schedule A–5, Adjustments to Expenses, will continue to be used for: expense recoveries (rebates, refunds, etc.); adjustments based on the income recieved; nonallowable costs to which general service costs are not applicable; and the amount applicable to Part B for hospital-based physicians (unless the contract includes a proportionate share of general service costs). These items will still be carried forward to Schedule A. (See Exhibit III–2.)

The following illustrates how certain types of nonreimbursable costs and adjustments should be handled:

A. *Research*—Where this is a material amount in the circumstances, a separate cost center should be established and the cost, determined on an accrual basis, should be carried forward to Worksheet B so that a proportionate share of general service costs may be distributed to it.

B. *Sale of Scrap, Waste, Etc.*—The income from these items should be used as a reduction of the applicable expense before these expenses receive their share of indirect expenses. If the applicable expense cannot be determined, for expediency the "Operation of Plant" account can be used.

C. *Rebates and Recovery of Expense*—The amount of the rebates or recovery should be used to reduce the applicable expense before these expenses receive their proportionate share of indirect expenses. A grant or gift applicable to a specific expense is not considered a recovery of expense and should not be applied until after the step-down has been completed. In computing the allowance in lieu of specific recognition of other costs (SSA–1563A) the total allowance cost must be reduced by the amount received from the gift or grant *before* computing the 1½% or 2% allowance.

D. *Gift, Flower, and Coffee Shops*—Where cost centers are maintained for these functions, the cost should be carried forward to Workshtet B and receive an allocable share of general service costs. After the allocation is made, the total cost of these functions must be excluded in determining reimbursable cost. In this case, income will not be used to reduce expenses. Where cost centers are not maintained for these functions, the income derived from them must be used to reduce total hospital expense. For expediency, the cost in the "Operation of Plant" account can be reduced.

E. *Amount Applicable to Part B for Hospital-Based Physicians*—Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on Schedule A–5. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate proportion of general service costs.

Those providers who report cost on SSA Form–1564—Combination Method, Estimated Percentage Bases—and SSA Form–1564A—Gross Ratio of Charges to Charges Basis—may determine that portion of general service costs attributable to the nonallowable cost centers in the following manner:

1. Determine the cost of those general service cost centers which directly or indirectly contribute to the functions performed within the nonallowable cost areas.

2. Determine the percentage that the costs of these contributing centers is to the total of all other costs (including nonallowable costs).

3. Apply the resulting percentage to the nonallowable costs to reflect the total adjustment for nonallowable cost.

An example of this calculation and its application is as follows:

Cost Centers Applicable to Nonallowable Cost Areas		Expense Per Books		Adjustments Increases (Decreases)	Adjusted Operating Expenses
Depreciation		$ 90,000			
Employee Health and Welfare		85,000			
Operation of Plant		115,000			
Maintenance of Plant		71,000			
Laundry and Linen Service		61,000			
Housekeeping		122,000			
Maintenance of Personnel		10,000			
Administrative and General		326,000			
Sub-Total	(A)	$ 880,000	(C)	($ 4,181)	$ 875,819
Nonallowable Cost Areas	(B)	10,000	(C)	4,181	
All Other Costs	(B)	2,095,000	(D)	($14,181)	2,095,000
Total Costs		$2,985,000		($14,181)	$2,970,819

$$\frac{\text{(A)}\quad 880{,}000}{\text{(B)}\quad 2{,}105{,}000} = 41.81\%$$

(C) $10,000 × .4181 = $4,181 — For expediency, this credit adjustment may be applied to Administrative and General Expense

(D) $10,000 + 4,181 = $14,181

The provider may use any other method which the intermediary has determined will be more accurate in developing the adjustment for nonallowable cost.

2330. REPORTING PERIOD

Cost reports are due on or before the last day of the third month following the close of the provider's accounting period. Specific details as to periods for cost report filing may be found in Chapter 24, § 2414.

2332. ILLUSTRATIVE EXAMPLES

2332.1 Step-Down Method (Using Form SSA–1562 and Related Schedules) Exhibit I—Under the step-down method, costs of the service departments which receive the least service from other departments and provide the greatest service to other departments are distributed first. As the costs of each cost center are distributed that cost center is closed. Each succeeding center's costs are distributed until all general service costs have been allocated to the revenue-producing and nonreimbursable cost centers. Exhibit I has been prepared using hypothetical amounts to demonstrate the application of this method.

2332.2 Double Apportionment Method (Using Worksheet B and B–1 of SSA–1562) Exhibit II—The double apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers or nonallowable cost centers.

A variation of this method acceptable for program purposes is illustrated in Exhibit II. Except for Depreciation and General and Administrative, the first or preliminary apportionment of expenses is made to all cost centers including the center being distributed.

Example: Employee Health and Welfare expenses of $121,081 on Worksheet B (Exhibit II–1).

The cost to be apportioned is arrived at as follows:

Line 3 Column 2	$103,169
Line 3 Column 3	17,912
Cost to be apportioned	$121,081

This cost of $121,081 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–3).

Example: Housekeeping expenses of $95,164 on Worksheet B (Exhibit II–1)

Line 7 Column 2	$74,720
" " " 3	12,973
" " " 4	7,144
" " " 5	108
" " " 6	117
" " " 7	102
Costs to be apportioned	$95,164

This cost of $95,164 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–3) including those nonrevenue-producing centers which preceded it in this allocation.

A portion of the Housekeeping costs is also distributed to the Housekeeping cost center.

In the second or final distribution, the balances are "stepped-down" to both nonrevenue as well as revenue producing cost centers except that each nonrevenue-producing center is closed and no amounts are distributed to centers which preceded it in the allocation.

Example: Employee Health and Welfare expenses of $4,472 on Worksheet B (Exhibit II–2)

The cost to be apportioned is arrived at as follows:

Line 3 Column 2	$4,399
Line 3 Column 3	73
Cost to be apportioned	$4,472

This cost of $4,472 is distributed to all centers based upon the statistics appearing on Worksheet B–1 (Exhibit II–4). In this second distribution, no cost is distributed to the Employee Health and Welfare cost centers or any nonrevenue-producing centers preceding it.

2332.3 Combination Method (Estimated Percentage Basis)—Using Form SSA–1564 and Related Schedules—Exhibit III—and Gross RCC Basis—Insofar as the Classification and Adjustment of Hospital Operating Expenses and Adjustments to Expenses are concerned these forms are identical and the same procedures would be followed for both methods. Exhibit III has been prepared using hypothetical amounts to illustrate the Combination Method using the Estimated Percentage Basis (Form SSA–1564).

2334. ILLUSTRATIVE EXAMPLES—HOME HEALTH AGENCIES

For illustration purposes, only those pages of Form SSA–1728 pertaining to cost finding were completed using hypothetical amounts.

All agencies must complete the white section of this report consisting of pages 1 through 4 and page 9. In addition each agency will complete one of the following sets of schedules, depending on the method used in determining costs.

2334.1 National League for Nursing—Method I—Exhibit IV——Those agencies which develop an average cost per visit by procedures developed by the National League for Nursing and known as Method I, or a variation of this method, will complete page 5, Schedule A–4, and Schedule A–5.

2334.2 National League for Nursing—Method II—Exhibit V— Those agencies which develop an average cost per visit by procedures developed by the National League for Nursing and known as Method II which entails determination of the cost of various classifications of home visits and other services by diagnoses and disciplines of the home health agency worker, or a refinement of this method, will complete page 6, Schedule A–6 and Schedule A–7 only if costs are to be reimbursed based on types of services provided.

2334.3 Combined PHS–NLN Method—Exhibit VI—Those agencies which develop an average cost per visit by the method jointly developed by the Public Health Service and the National League for Nursing or a variation of this method, will complete page 7, Schedule A–8.

2334.4 Calculation of HI Program Costs of Home Health Service Based on RCCAC Apportionment—Exhibit VII—Home health agencies which have developed a charge structure which is related to cost and which is systematically applied to services provided may use the Gross RCCAC Method to apportion costs to the Medicare program. Page 8, Schedule 9 and Schedule 10 of Form SSA–1728 must be completed.

2334.5 Home Health Services—Cost Adjustments for Non-Covered Hospital-Based Home Health Services and Direct Expense Analysis—Exhibit VIII—These schedules are used in conjunction with Form SSA–1562 when the agency is hospital-based. The purpose of the Cost Adjustments for Non-Covered Home Health Services is to eliminate from the total costs of operating the home health agency service department the costs of non-covered services as well as costs of activities not in connection with home visits and expenditures not related to the program for which no charges are made. Such eliminations should be made from actual cost records or costs apportioned on the basis of time or number of units or other rational bases. Workpapers must be included to support the non-covered adjustments contained in Schedule A–3. Examples of non-covered costs are meals on wheels (home delivered meals), clinics, conferences, and group teaching not related to Medicare, i.e., well-baby clinics and other non-visiting type of expenditures.

The direct expense analysis provides for an itemization of total direct costs included in the Home Health Cost Center (Form SSA–1562, Column 1 of Worksheet B). Hospitals may substitute their own direct cost itemization in lieu of using the expense groupings listed on Schedule A–4 if they are unable to list such direct costs in the format contained on Schedule A–4.

325-263 O - 68 - 3

STEP-DOWN METHOD

PROVIDER NO. 00-0000

RECLASSIFICATION OF TRIAL BALANCE OF EXPENSES

PERIOD 7/1/66 - 12/31/66

Schedule A

LINE NO.	ACCOUNT	TRIAL BALANCE OF DIRECT EXPENSES			TRIAL BALANCE RE-CLASSIFIED FOR COST APPORTIONMENT	ADJUSTMENTS TO EXPENSES *Increases and (Decreases)* *(See Sch. A-5)*	NET EXPENSES FOR COST APPORTIONMENT *
		SALARIES	OTHER	TOTAL	TOTAL		
		1	2	3	4	5	6
1	Administration and General	$ 120,893	$ 207,223	$ 328,116	$ 225,623	$ (2,782)	$ 222,841
2	Employee Health & Welfare Bene.	-	-	-	102,766	-	102,766
3	Dietary – Raw Food	-	127,543	127,543	68,440	-	68,440
4	Dietary – Other Expense	41,676	3,137	44,813	25,096	-	25,096
5	Cafeteria	-	-	-	73.147	(18,149)	54,998
6	Housekeeping	63,013	11,120	74,133	74,133	-	74,133
7	Laundry and Linen	23,959	12,901	36,860	36,860	-	36,860
8	Maintenance of Personnel	3,745	936	4,681	4,681	(1,637)	3,044
9	Operation of Plant	9,207	34,636	43,843	43,843	-	43,843
10	Maintenance of Plant	24,129	22,273	46,402	46,402	-	46,402
11	Nursing Service	437,750	38,065	475,815	475,815	-	475,815
12	Nursing School	24,765	4,717	29,482	29,482	(5,428)	24,054
13	Medical-Surgical Expense	57,722	11,637	69,359	-	-	-
14	Intern-Resident Service	-	-	-	50,000	-	50,000
15	Oxygen Therapy	-	-	-	-	-	-
16	Medical Supplies and Expense	-	-	-	19,359	(2,386)	16,973
17	Pharmacy	8,936	46,914	55,850	55,850	-	55,850
18	Medical Records	23,101	2,855	25,956	25,956	(1,297)	24,659
19	Social Service	3,116	300	3,416	3,416	-	3.416
20	Operating Rooms	52,533	27,042	79,575	79,575	-	79,575
21	Delivery Rooms	6,869	3,539	10,408	10,408	-	10,408
22	Anesthesia	2,698	4,797	7,495	7,495	-	7,495
23	X-Ray	38,170	50,598	88,768	88,768	(24,608)	64,160
24	Laboratory	70,639	29,960	100,599	93,704	(19,482)	74,222
25	Blood Bank	-	-	-	6,895	-	6,895
26	Research - Organized	4,320	1,080	5,400	5,400	-	5,400
27	Physical Therapy	48,734	12,183	60,917	60,917	-	60,917
28	Nursery	-	-	-	5,673	-	5,673
29	Fund Raising	12,994	3,413	16,407	16,407	-	16,407
30	Emergency Service	1,030	226	1,256	1,256	-	1,256
31	Depreciation–Buildings, etc.	-	42,257	42,257	42,257	-	42,257
32	Depreciation–Movable Equipment	-	35,823	35,823	35,823	-	35,823
33	Interest Expense	-	273	273	-	-	-
34	Total Expenses	$ 1,079,999	$ 735,448	$ 1,815,447	$ 1,815,447	$ (75,769)	$ 1,739,678
35	2% Allowance (Column 6) (A)						34,788 (2)
36	Total Net Expenses						$ 1,774,466 (3)

(1)

*NOTE: Transfer the amounts on lines 1 through 36, Column 6, above, to Column 1, Worksheet B.
If hospital practice provides for combining certain of the above amounts this will be acceptable. The prevailing basis for allocation for the center in which combined should be used.

FORM SSA-1562 (9-66) (A) Show computation on Form SSA-1563A

(1) From Schedule A-5
(2) Form SSA-1563A
(3) To Worksheet B

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23-15

EXHIBIT I

STEP-DOWN METHOD

PROVIDER NO. 00-0000 EXHIBIT I-1

ADMINISTRATION AND GENERAL EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66 — Schedule A-1

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 1, Columns 1, 2 and 3, Schedule A)*	$ 120,893	$ 207,223	$ 328,116
2.	Personnel Department	9,506	635	10,141
3.	Employee Health Service	10,867	2,152	13,019
4.	Hospitalization Insurance		5,755	5,755
5.	Workmen's Compensation		10,550	10,550
6.	Employee Group Insurance		2,877	2,877
7.	Social Security Taxes		36,446	36,446
8.	Annuity Premiums, Past Service Benefits, and Pensions voted by Governing Board		23,978	23,978
9.	Total Employee Health and Welfare *(lines 2 thru 8; to Sch. A. line 2. Column 4)*	$ 20,373	$ 82,393	$ 102,766
10.	Remaining Administration and General	$ 100,520	$ 124,830	$ 225,350
11.	Interest *(from Schedule A Column 3, line 33)* and Other Expense to be added to Administration and General for cost allocation		273	273
12.	Interest expense and remaining administration and general expenses and other expenses *(line 10 +11; to Schedule A. line 1, Column 4)*	$ 100,520	$ 125,103	$ 225,623

DIETARY EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66 — Schedule A-2

A. Analysis of Dietary–Raw Food:

	Value of Raw Food *(From line 3, column 2, Schedule A)*		$ 127,543
	Issued to or prepared for use in:		
1	Cafeteria	$ 53,430	
2	Nursery	5,673	
3	Dietary–Raw Food	68,440	
4	TOTAL *(Same as line A)*		$ 127,543

B. Analysis of Dietary–Other *(from line 4, Columns 1, 2 and 3, Schedule A)*

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Cafeteria	$ 18,337	$ 1,380	$ 19,717
2.	Dietary	23,339	1,757	25,096
3.	TOTAL	$ 41,676	$ 3,137	$ 44,813

C. Summary of Analysis:

Dietary–Raw Food *(from A, line 3 above)* *(to appear on line 3 in Column 4, Schedule A)*		$ 68,440
Dietary–Other–Salaries *(from B, line 2, column 1 above)*		
Salaries		$ 23,339
Other expense *(from B, column 2, line 2 above)*		1,757
Total–Other *(to line 4, Column 4, Schedule A)*		$ 25,096
Cafeteria		
Salaries *(from B, column 1, line 1 above)*		$ 18,337
Raw food *(from A, line 1, above)*	$ 53,430	
Other *(from B, column 2, line 1 above)*	1,380	
Total Other		54,810
Total Salaries and Other *(to Line 5, Column 4, Schedule A)*		$ 73,147
Nursery *(from A, line 2 above) (to line 28, Column 4, Schedule A)*		$ 5,673

STEP-DOWN METHOD

EXHIBIT I-2

PROVIDER NO. 00-0000

MEDICAL-SURGICAL EXPENSE ANALYSIS

PERIOD: 7/1/66 - 12/31/66

Schedule A-3

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 13, Columns 1, 2 and 3, Schedule A)*	$ 57,722	$ 11,637	$ 69,359
2.	Intern-Resident Service *(to line 14, Column 4, Schedule A)*	$ 50,000	$	$ 50,000
3.	Oxygen Therapy *(to line 15, Column 4, Schedule A)*	-		-
4.	Medical Supplies and Expense *(to line 16, Column 4, Schedule A)*	7,722	11,637	19,359
5.				
6.	Total Transferred *(Same as line 1 above)*	$ 57,722	$ 11,637	$ 69,359

LABORATORY EXPENSE ANALYSIS

PERIOD: 7/1/66 - 12/31/66

Schedule A-4

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 24, Columns 1, 2 and 3, Schedule A)*	$ 70,639	$ 29,960	$ 100,599
2.	Blood Bank *(to line 25, Column 4, Schedule A)*	$ 3,172	$ 3,723	$ 6,895
3.				
4.	Remaining Laboratory *(to line 24, Column 4, Schedule A)*	67,467	26,237	93,704
5.	Total Transferred *(same as line 1 above)*	$ 70,639	$ 29,960	$ 100,599

EXHIBIT I-3

STEP-DOWN METHOD

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Schedule A-5

ADJUSTMENTS TO EXPENSES

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT*	AMOUNT	EXPENSE CLASSIFICATION ON SCHEDULE A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin & Gen	1
2.	Radio and television service	B	(594)	Admin & Gen	1
3.	Laundry and Linen Service				7
4.	Vending Machines Commission				9
5.	Employee and guest meals	B	(18,149)	Dietary	5
6.	Sale of drugs to other than patients				17
7.	Sale of medical and surgical supplies to other than patients				16
8.	Sale of medical records and abstracts	B	(1,297)	Medical Records	18
9.	Sale of scrap, waste, etc.	B	(1,484)	Admin & Gen	1
10.	Rental of quarters to employees and others	B	(1,637)	Maint. of Personnel	8
11.	Rental of hospital space				9
12.	Payments received from specialists				1
13.	Trade, quantity, time, and other discounts on purchases	B	(2,386)	Medical Supplies and Expense	16
14.	Rebates and refunds of expenses				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				1
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	Nursing School	12
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	23 24
21.	Fund raising expenses				Various
22.	Depreciation				31/32
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	**TOTAL**		$ (75,769)		

FORM SSA-1562 (9-66)

*BASIS FOR ADJUSTMENT: A – Cost B – Amount Received

To Sch A

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COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
			BLDG. AND FIXTURES, ETC.	MOVABLE EQUIPMENT								
		1	1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers											
1a	Provision for Depreciation – Bldg. & Fixtures	$ 42,257	$ 42,257									1a
1b	Provision for Depreciation – Movable Equip.	35,823		$35,823								1b
2	Administration & General	257,629	2,887	2,006	$ 262,522	$262,522						2
3	Employee Health & Welfare	102,766	297	106	103,169	17,913	$121,082					3
4	Operation of Plant	43,843	494	680	45,017	7,816	1,162	$ 53,995				4
5	Maintenance of Plant	46,402	249	574	47,225	8,200	3,046	349	$ 58,820			5
6	Laundry and Linen Service	36,860	1,139	541	38,540	6,692	3,025	1,594	1,748	$ 51,599		6
7	Housekeeping	74,133	71	513	74,717	12,973	7,955	100	110	124	$ 95,979	7
8	Dietary–Raw Food	68,440	-	-	68,440	11,883	-	-	-	-	-	8
9	–Other	25,096	1,298	291	26,685	4,633	2,946	1,817	1,992	519	-	9
10	Cafeteria	54,998	1,354	1,248	57,600	10,001	2,315	1,895	2,078	372	-	10
11	Maintenance of Personnel	3,044	7,695	485	11,224	1,949	473	10,769	11,808	1,533	11,627	11
12	Nursing Service	475,815	462	481	476,758	82,779	55,262	647	709	420	-	12
13	Medical Supplies & Expense	16,973	266	895	18,134	3,149	975	372	408	100	730	13
14	Pharmacy	55,850	197	493	56,540	9,817	1,128	276	302	22	730	14
15	Medical Records	24,659	262	462	25,383	4,407	2,916	367	403	16	2,944	15
16	Social Service	3,416	138	200	3,754	652	393	193	211	143	730	16
17	Nursing School	24,054	1,169	2,091	27,314	4,743	3,126	1,636	1,793	758	4,501	17
18	Intern-Resident Service	50,000	852	269	51,121	8,876	6,312	1,193	1,308	885	-	18
19	Organized Research	5,400	40	9	5,449	946	545	55	61	24	167	19
20	Fund Raising Activities	16,407	138	355	16,900	2,934	1,640	194	213	72	405	20
	Special Service Cost Centers											
21	Operating Rooms	79,575	1,979	6,430	87,984	15,277	6,632	2,770	3,037	11,220	357	21
22	Delivery Rooms	10,408	853	710	11,971	2,079	867	1,194	1,309	3,223	1,657	22
23	Anesthesia	7,495	11	469	7,975	1,385	341	16	17	369	-	23
24	X-Ray	64,160	941	1,729	66,830	11,604	4,819	1,317	1,444	915	2,944	24
25	Laboratory	74,222	1,114	875	76,211	13,233	8,517	1,559	1,710	23	2,351	25
26	Blood Bank	6,895	173	450	7,518	1,305	400	242	266	18	338	26
27	Oxygen Therapy	-										27
28	Physical Therapy	60,917	537	786	62,240	10,809	6,157	752	824	1,328	2,757	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients		13,141	11,094	24,235	4,208		18,388	20,162	24,849	56,736	32
33	Nursery	5,673	1,301	282	7,256	1,260		1,821	1,997	3,413	1,118	33
	Outpatient Cost Centers											
34	Outpatients		2,780	405	3,185	553		3,892	4,267	842	4,594	34
35	Emergency	1,256	419	894	2,569	446	130	587	643	201	1,293	35
36	Private Ambulatory											36
37	TOTAL	$1,774,466	$ 42,257	$35,823	$1,774,466	$262,522	$ 121,082	$ 53,995	$ 58,820	$ 51,599	$ 95,979	37

PROVIDER NO. 00-0000 EXHIBIT I-4

PERIOD: 7/1/66 - 12/31/66

Worksheet B

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTE-NANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2 thru 19, Lines 21-37) (To Sched. C)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a													1a
1b													1b
2													2
3													3
4													4
5													5
6													6
7													7
8	$ 80,323												8
9	594	$ 39,186											9
10	660	324	$ 75,245										10
11	137	68	376	$ 49,964									11
12	14,545	7,149	42,212	5,047	$685,528								12
13	248	122	677	-	7,541	$ 32,456							13
14	302	149	903	-	-	-	$ 70,169						14
15	770	378	2,257	-	7,541	-	-	$47,382					15
16	110	54	301	505	-	-	-	-	$ 7,046				16
17	825	405	2,408	17,664	32,219	-	-	-	-	$ 97,392			17
18	1,650	811	4,816	25,739	-	-	-	-	-	-	$102,711		18
19	-	-	-	-	-	-	-	-	-	-	-	$ 7,247	19 (1)
20	-	-	-	-	-	-	-	-	-	-	-	22,358	20 (1)
21	1,760	865	5,117	-	54,157	4,055	8,521	-	-	10,323	18,850	230,925	21 (2)
22	220	108	602	-	23,308	3,052	3,780	-	-	9,034	13,432	75,836	22 (2)
23	83	41	226	-	-	-	9,633	-	-	-	-	20,086	23 (2)
24	1,265	622	3,687	-	26,050	-	2,581	-	-	-	-	124,078	24 (2)
25	2,255	1,108	6,546	-	30,849	-	1,454	-	-	-	-	146,026	25 (2)
26	110	54	301	-	4,799	-	-	-	-	-	-	15,351	26 (2)
27													27
28	1,622	797	4,741	1,009	15,082	1,656	-	-	-	-	-	109,774	28 (2)
29													29
30													30
32	53,107	26,102	-	-	361,275	20,805	35,873	38,853	7,046	65,975	67,948	825,562	32 (2)
33	33	16	-	-	35,646	1,070	2,897	474	-	7,411	2,481	66,893	33 (2)
34					76,093	97	2,186	6,634	-	4,201	-	106,544	34 (2)
35	27	13	75		10,968	1,721	3,244	1,421	-	448	-	23,786	35 (2)
36													36
37	* $ 80,323	** $ 39,186	** $ 75,245	$ 49,964	$685,528	$ 32,456	$ 70,169	$47,382	$ 7,046	$ 97,392	$102,711	$1,774,466	37
												Exclusions 29,605	(1)
												$1,744,861	(2)

*From Worksheet B-1-1 **From Worksheet B-1-2 (2) To Sch C

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COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING (Hours of Service)	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers										
1a	Provision for Depreciation – Bldg. & Fixtures	213,150									1a
1b	Provision for Depreciation – Movable Equip.		414,043								1b
2	Administration and General	14,564	23,182		1,511,944						2
3	Employee Health and Welfare	1,500	1,220		103,169	959,106					3
4	Operation of Plant	2,490	7,860		45,017	9,207	194,596				4
5	Maintenance of Plant	1,256	6,639		47,225	24,129	1,256	193,340			5
6	Laundry and Linen Service	5,746	6,252		38,540	23,959	5,746	5,746	647,100		6
7	Housekeeping	360	5,925		74,717	63,013	360	360	1,556	63,118	7
8	Dietary–Raw Food				68,440						8
9	–Other	6,549	3,360		26,685	23,339	6,549	6,549	6,510		9
10	Cafeteria	6,830	14,427		57,600	18,337	6,830	6,830	4,666		10
11	Maintenance of Personnel	38,813	5,610		11,224	3,745	38,813	38,813	19,224	7,646	11
12	Nursing Service	2,332	5.559		476,758	437,750	2,332	2,332	5,268		12
13	Medical Supplies and Expense	1,341	10,342		18,134	7,722	1,341	1,341	1,254	480	13
14	Pharmacy	993	5,694		56,540	8,936	993	993	270	480	14
15	Medical Records	1,324	5,340		25,383	23,101	1,324	1,324	200	1,936	15
16	Social Service	695	2,316		3,754	3,116	695	695	1,792	480	16
17	Nursing School	5,895	24,175		27,314	24,765	5,895	5,895	9,504	2,960	17
18	Intern-Resident Service	4,300	3,105		51,121	50,000	4,300	4,300	11,103		18
19	Organized Research	200	100		5,449	4,320	200	200	300	110	19
20	Fund Raising Activities	700	4,100		16.900	12,994	700	700	900	266	20
	Special Service Cost Centers										
21	Operating Rooms	9,983	74,314		87,984	52,533	9,983	9,983	140,707	235	21
22	Delivery Rooms	4,302	8,204		11,971	6,869	4,302	4,302	40,425	1,090	22
23	Anesthesia	56	5,421		7,975	2,698	56	56	4,625		23
24	X-Ray	4,748	19,985		66,830	38,170	4,748	4,748	11,472	1,936	24
25	Laboratory	5,620	10,109		76,211	67,467	5,620	5,620	2,921	1,546	25
26	Blood Bank	873	5,202		7,518	3,172	873	873	227	222	26
27	Oxygen Therapy										27
28	Physical Therapy	2,709	9,083		62,240	48,734	2,709	2,709	16,660	1,813	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients	66,267	128,233		24,235		66,267	66,267	311,628	37,312	32
33	Nursery	6,564	3,265		7,256		6,564	6,564	42,802	735	33
	Outpatient Cost Centers										
34	Outpatients	14,025	4,689		3,185		14,025	14,025	10,564	3,021	34
35	Emergency	2,115	10,332		2,569	1,030	2,115	2,115	2,522	850	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$ 42,257	$ 35,823	$	$ 262,522	$ 121,082	$ 53,995	$ 58,820	$ 51,599	$ 95,979	37
38	Unit Cost Multiplier	.19825	.08652		.17363	.12624	.27747	.30423	.07974	1.52063	38

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*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

PROVIDER NUMBER: 00 - 0000 EXHIBIT I-5

PERIOD 7/1/66 - 12/31/66 Worksheet B-1

LINE NO.	DIETARY RAW FOOD Weighted (Meals Served)	DIETARY OTHER Weighted (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
1a												1a
1b												1b
2												2
3												3
4												4
5												5
6												6
7												7
8	1,143,476											8
9	8,456	1,135,020										9
10	9,395	9,395	93,394									10
11	1,955	1,955	467	99								11
12	207,060	207,060	52,393	10	413,263							12
13	3,525	3,525	840		4,546	18,071						13
14	4,305	4,305	1,121				53,387					14
15	10,960	10,960	2,801		4,546			100%				15
16	1,565	1,565	374	1								16
17	11,745	11,745	2,989	35	19,423					88,982		17
18	23,485	23,485	5,978	51							61,175	18
19												19
20												20
21	25,050	25,050	6,351		32,648	2,258	6,483			9,432	11,227	21
22	3,130	3,130	747		14,051	1,699	2,876			8,254	8,000	22
23	1,175	1,175	281				7,329					23
24	18,005	18,005	4,576		15,704		1,964					24
25	32,095	32,095	8,125		18,597		1,106					25
26	1,565	1,565	374		2,893							26
27												27
28	23,095	23,095	5,885	2	9,092	922						28
29												29
30												30
32	756,050	756,050			217,790	11,584	27,294	82%	100%	60,278	40,470	32
33	470	470			21,489	596	2,204	1%		6,771	1,478	33
34					45,872	54	1,663	14%		3,838		34
35	390	390	92		6,612	958	2,468	3%		409		35
36												36
37	$ 80,323	$ 39,186	$75,245	$ 49,964	$ 685,528	$ 32,456	$ 70,169	$ 47,382	$ 7,046	$ 97,392	$ 102,711	37
38	.07025	.034524	.80567	504.68687	1.65882	1.79603	1.31435	47,382	7,046	1.09451	1.67897	38

STEP-DOWN METHOD

EXHIBIT I-6

PROVIDER NO. 00-0000

COST APPORTIONMENT – DIETARY–RAW FOOD (Omit Cents)	PERIOD 7/1/66 - 12/31/66	Worksheet B-1-1

Computation of the amount of cost to be allocated to each "weighted" meal served, listed in Column 1 or Column 3, below.

Dietary–Raw Food *(from line 8, Col. 9 of Worksheet B)* $ 80323 = $.07024

Total Meals Served *(from total of Col. 1 or Col. 3, below)* 1143476 Per Meal

WORK SHEET B LINE NO.	COST CENTER	STATISTICAL DATA *(Meals Served)*	WEIGHTING FACTOR	MEALS SERVED "WEIGHTED" AS TO DIFFERENCE	COST APPORTIONMENT
		1	2	3	4
9	Dietary–Other	2,114	4	8,456	$ 594
10	Cafeteria	1,879	5	9,395	660
11	Maintenance of Personnel	391	5	1,955	137
12	Nursing Service	41,412	5	207,060	14,545
13	Medical Supplies & Expense	705	5	3,525	248
14	Pharmacy	861	5	4,305	302
15	Medical Records	2,192	5	10,960	770
16	Social Service	313	5	1,565	110
17	Nursing School	2,349	5	11,745	825
18	Intern-Resident Service	4,697	5	23,485	1,650
21	Operating Rooms	5,010	5	25,050	1,760
22	Delivery Rooms	626	5	3,130	220
23	Anesthesia	235	5	1,175	83
24	X-Ray	3,601	5	18,005	1,265
25	Laboratory	6,419	5	32,095	2,255
26	Blood Bank	313	5	1,565	110
28	Physical Therapy	4,619	5	23,095	1,622
32	Inpatients	151,210	5	756,050	53,107
33	Nursery	470	1	470	33
34	Outpatients				
35	Emergency	78	5	390	27
37	TOTAL	229,494		1,143,476	$ 80,323

NOTE: Weighting factor for meals may be used if present practice, otherwise regular meal count may be used.

STEP-DOWN METHOD

EXHIBIT I-7

PROVIDER NO. 00-0000

COST APPORTIONMENT – DIETARY–OTHER (Omit Cents)	PERIOD 7/1/66–12/31/66	Worksheet B–1–2

PART A – DETERMINATION OF THE PORTION OF DIETARY – OTHER COST TO BE DISTRIBUTED TO CAFETERIA REPRESENTING FOOD PREPARATION AND DIETARY ADMINISTRATION SERVICES

1. Total Food Preparation and Dietary Administration Costs–per Analysis of Dietary Expense Accounts	
Dietary Office–Supplies and Expense	$
Dietary Administration–Salaries and Wages	
General Food Preparation–Salaries and Wages	
General Food Preparation–Supplies and Expense	
TOTAL *(To Formula Below)*	$

2. Computation of the Percentage of Raw Food Distributed to the Cafeteria	AMOUNT	PERCENT
Value of Raw Food Distributed to, or used by Cafeteria *(from Schedule A-2, line 1)*	$	
Value of Raw Food Distributed to, or used by Dietary *(from Schedule A-2, line 3)*		
TOTAL	$	

3. Amount of Dietary Cost to be Distributed to Cafeteria

$	×	%	=	$
TOTAL DIETARY FOOD PREPARATION AND ADMINISTRATION COST – FROM ABOVE		PERCENTAGE OF VALUE OF RAW FOOD USED BY CAFETERIA		AMOUNT OF DIETARY COST TO BE DISTRIBUTED TO THE CAFETERIA *(enter on line 2, Part B, below)*

PART B

1. Total Accumulated Dietary–Other costs to be Distributed *(from line 9, Column 10, Worksheet B)*	$
2. Less Amount to be Distributed to Cafeteria (as determined in Part A, above) *(to line 10, Col. 10, Worksheet B)*	
3. Balance of Dietary–Other costs still to be Distributed per computation below.	$

DISTRIBUTION OF THE BALANCE OF DIETARY–OTHER COSTS:

Computation of the amount of cost to be allocated for each meal served, listed in Column 1, below.

Accumulated Dietary–Other costs to be Distributed: *(from line 3, above)* $ 39,186 / 1,135,020 = $.03452 per meal "Weighted"

Total Meals Served *(from total of Column 1, below)*, 39,186 / 229,494 = $.17075 average cost per meal

WORK SHEET B LINE NO.	DEPARTMENT OR ACTIVITY	STATISTICAL DATA *(Meals Served)* "Weighted"	COST APPORTIONMENT
		1	2
10	Cafeteria	9,395	$ 324
11	Maintenance of Personnel	1,955	68
12	Nursing Service	207,060	7,149
13	Medical Supplies and Expense	3,525	122
14	Pharmacy	4,305	149
15	Medical Records	10,960	378
16	Social Service	1,565	54
17	Nursing School	11,745	405
18	Intern-Resident Service	23,485	811
21	Operating Rooms	25,050	865
22	Delivery Rooms	3,130	108
23	Anesthesia	1,175	41
24	X-Ray	18,005	622
25	Laboratory	32,095	1,108
26	Blood Bank	1,565	54
28	Physical Therapy	23,095	797
32	Inpatients	756,050	26,102
33	Nursery	470	16
34	Outpatients		
35	Emergency	390	13
37	TOTAL	1,135,020	$ 39,186
		To Worksheet B-1, Col. 10	To Worksheet B, Column 10

FORM SSA-1562 (9-66)
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23-26

PROVIDER NO. 00-0000

DEPARTMENTAL COST ALLOCATION (Omit Cents)
(For Basis see Worksheet C-1 – Page 10)

PERIOD 7/1/66 12/31/66

Schedule C

DISTRIBUTION BASIS: [X] RATIO OF CHARGES TO CHARGES APPLIED TO COST [] STATISTICAL (OCCASIONS OF SERVICE) IF CHECKED, FURNISH DETAIL SCHEDULES [] OTHER

LINE NO.	COST CENTER	ACCUMULATED COSTS *(from Column 20, lines 21 to 37 of Worksheet B)*	INPATIENTS	NURSERY	OUTPATIENTS	EMERGENCY	PRIVATE AMBULATORY
		1	2	3	4	5	6
1	SPECIAL COST CENTERS Operating Rooms	$ 230,925	$ 227,579	$	$ 670	$	$ 2,676
2	Delivery Rooms	75,836	75,836				
3	Anesthesia	20,086	17,899	379	362		1,446
4	X-Ray	124,078	89,518	1,756	6,561		26,243
5	Laboratory	146,026	132,611		2,682		10,733
6	Blood Bank	15,351	14,345		201		805
7	Oxygen Therapy						
8	Physical Therapy	109,774	98,725		2,210		8,839
9	Cost of Medical Supplies Sold						
10	Cost of Drugs Sold						
	INPATIENT COST CENTERS						
11	Inpatients	825,562	825,562				
12	Nursery	66,893		66,893			
	OUTPATIENT COST CENTERS						
13	Outpatients	106,544			89,497		17,047
14	Emergency	23,786				23,786	
15	Private Ambulatory	–	–	–	–	–	–
16	TOTAL	$ 1,744,861	$ 1,482,075	$ 69,028	$ 102,183	$ 23,786	$ 67,789

FORM SSA-1562 (9-66)

Form SSA 1563 Page 2

Sum to Form SSA-1563 Page 3, line 4

Rev. 4

STEP-DOWN METHOD

EXHIBIT I-9

PROVIDER NO. 00-0000

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DEPARTMENTAL COST ALLOCATION (Omit Cents)
TOTAL GROSS CHARGES TO CHARGES BASIS (*Applied on Schedule C*)

PERIOD 7/1/66 - 12/31/66

Schedule C-1

LINE NO.	COST CENTER	TOTAL GROSS CHARGES (*All Patients*)	TOTAL GROSS CHARGES (*All Inpatients*)	TOTAL GROSS CHARGES (*All Nursery*)	TOTAL GROSS CHARGES (*All Outpatients*)	TOTAL GROSS CHARGES (*All Emergency*)	TOTAL GROSS CHARGES (*All Private Ambulatory*)
		1	2	3	4	5	6
	SPECIAL COST CENTERS		$ 198,160	$	$ 583	$	$ 2,331
1	Operating Rooms	201,074	% 98.551	%	% 00.290	%	% 01.159
			$ 27,360	$	$	$	$
2	Delivery Rooms	27,360	% 100.0	%	%	%	%
			$ 18,892	$ 400	$ 382	$	$ 1,526
3	Anesthesia	21,200	% 89,113	% 1.887	% 01.802	%	% 07.198
			$ 127,728	$ 2,505	$ 9,361	$	$ 37,445
4	X-Ray	177,039	% 72.147	% 1.415	% 05.288	%	% 21.150
			$ 165,763	$	$ 3,354	$	$ 13,416
5	Laboratory	182,533	% 90.813	%	% 01.837	%	% 07.350
			$ 15,782	$	$ 221	$	$ 886
6	Blood Bank	16,889	% 93.445	%	% 01.309	%	% 05.246
			$	$	$	$	$
7	Oxygen Therapy		%	%	%	%	%
			$ 106,583	$	$ 2,386	$	$ 9,543
8	Physical Therapy	118,512	% 89.935	%	% 02.013	%	% 08.052
			$	$	$	$	$
9	Cost of Medical Supplies Sold		%	%	%	%	%
			$	$	$	$	$
10	Cost of Drugs Sold		%	%	%	%	%
	INPATIENT COST CENTERS		$ 904,248				
11	Inpatients	904,248	% 100.00	—	—	—	—
				$ 60,000			
12	Nursery	60,000	—	% 100.00	—	—	—
	OUTPATIENT COST CENTERS				$ 103,616	$	$ 19,736
13	Outpatients	123,352	—	—	% 84.000	%	% 16.000
					$	$ 26,015	$
14	Emergency	26,015	—	—	%	% 100.00	%
					$	$	$
15	Private Ambulatory		—	—	%	%	%
16	TOTAL	$ 1,858,222	$ 1,564,516	$ 62,905	$ 119,903	$ 26,015	$ 84,883

FORM SSA-1562 (9-66) *Ambulance 9,649

1,867,871

Sources: Charges - Form SSA-1563 Page 2 and 3

*Ambulance is covered by a separate set of reimbursement schedules

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STEP-DOWN METHOD

EXHIBIT I-10

PROVIDER NO. 00-0000

COST PER UNIT OF SERVICE	PERIOD 7/1/66 - 12/31/66	Schedule D

PART I – SPECIAL SERVICES COSTS

COST CENTER	TOTAL COSTS (from lines 21 to 36, Col. 20 of Worksheet B)	SERVICES RENDERED		AVERAGE COST PER UNIT (Col. 1 ÷ Col. 3)
		UNIT	TOTAL	
	1	2	3	4
SPECIAL SERVICE COST CENTERS				
Operating Rooms	$ 230,925	minutes	529,875	$.43581
Delivery Rooms	75,836	deliveries	1,442	52.59085
Anesthesia	20,086	minutes	345,494	.05814
X–Ray	124,078	films	43,229	2.87025
Laboratory	146,026	examinations	96,522	1.51288
Blood Bank	15,351	transfusions	707	21.71287
Oxygen Therapy		minutes		
Physical Therapy	109,774	treatments	31,789	3.45321
Cost of Medical Supplies Sold		–	–	–
Cost of Drugs Sold		–	–	–
INPATIENT COST CENTERS				
Inpatients	825,562	patient days	25,836	31.95394
Nursery	66,893	newborn days	2,666	25.09115
OUTPATIENT COST CENTERS				
Outpatients	106,544	occasions of service	15,203	7.00809
Emergency	23,786	occasions of service	428	55.57477
Private Ambulatory	–	–	–	–

PART 2 – INPATIENT AND OUTPATIENT COSTS

COST CENTER	TOTAL COSTS (from line 16, Columns 2 to 6 of Schedule C)	SERVICES RENDERED		AVERAGE COST PER UNIT (Col. 1 ÷ Col. 3)
		UNIT	TOTAL	
	1	2	3	4
INPATIENT COST CENTERS				
Inpatients	$ 1,484,210	patient days	25,836	$ 57.44736*
Nursery	66,893	newborn days	2,666	25.09115
OUTPATIENT COST CENTERS				
Outpatients	102,183	occasions of serivce	8,704	11.73977
Emergency	23,786	occasions of service	428	55.57477
Private Ambulatory	67,789	occasions of service	6,499	10.43068

*Includes inpatient daily costs plus ancillary charge

Form Approved
Budget Bureau No. 72-R763

INSERT AS PAGE 9 IN FORM SSA-1563	PROVIDER NO. 00-0000
	PERIOD 7/1/66 - 12/31/66

QUESTIONNAIRE

1. How was depreciation included in cost statement calculated?

☐ Actual ☐ Optional Allowance

If Actual: ☒ Straight Line ☐ Sum-of-Years Digits

☐ Declining Balance

2. Is depreciation funded? ☐ Yes ☒ No

If yes: What Basis? _____

Where recorded? _____

Balance in fund at end of period $ _____

3. Were there any gains or losses on disposals of capital assets during period? ☐ Yes ☒ No

Included in Expenses? ☐ Yes ☒ No

Where? _____ Amounts? _____

NON-PROPRIETARY PROVIDERS' WORKSHEET FOR COMPUTING ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS
(REFER TO PRINCIPLE OF REIMBURSEMENT 1-11) (REG. SEC. 405.428)

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

LINE NO.	DESCRIPTION	AMOUNTS (Omit Cents)
1.	Total allowable cost Form SSA-1562 Page 1, Line 34	$ 1,739,678
2.	Less: Interest expense Form SSA-1562 Page 1, Line 33	273
3.	Allowable cost less interest expense *(line 1 minus line 2)*	$ 1,739,405
4.	Allowance *(2% x line 3)*	$ 34,788

To Form SSA-1562, Page 1

EXHIBIT II-1

DOUBLE APPORTIONMENT METHOD

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
			BLDG. AND FIXTURES, ETC.	MOVABLE EQUIPMENT								
		1	1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers					262,508	121,081	53,939	58,417	50,926	95,164	
1a	Provision for Depreciation – Bldg. & Fixtures	$ 42,257	$ 42,257									1a
1b	Provision for Depreciation – Movable Equip.	35,823		$ 35,823								1b
2	Administration & General	257,629	2,873	2,006	$ 262,508	$	11,261	3,668	3,972	204	6,471	2
3	Employee Health & Welfare	102,766	296	107	103,169	17,912	$ 2,301	378	409	51	666	3
4	Operation of Plant	43,843	507	681	45,031	7,818	1,090	$ 647	701	102	1,142	4
5	Maintenance of Plant	46,402	254	573	47,229	8,200	2,664	324	$ 350	458	571	5
6	Laundry and Linen Service	36,860	1,141	537	38,538	6,691	2,664	1,456	1,577	$ 102	2,569	6
7	Housekeeping	74,133	85	502	74,720	12,973	7,144	108	117	102	$ 190	7
8	Dietary–Raw Food	57,928			57,928							8
9	–Other	41,590	1,198	693	43,481	11,933	2,125	1,529	1,656	390	2,698	9
10	Cafeteria	49,016	1,464	847	51,327	14,585	2,597	1,869	2,024	476	3,297	10
11	Maintenance of Personnel	3,044	7,691	502	11,237	1,951	363	9,817	10,633	1,477	17,320	11
12	Nursing Service	475,815	465	466	476,746	82,773	49,159	593	643	407	1,047	12
13	Medical Supplies & Expense	16,973	254	896	18,123	3,147	848	324	350	102	571	13
14	Pharmacy	55,850	211	502	56,563	9,821	969	270	292	51	476	14
15	Medical Records	24,659	254	466	25,379	4,406	2,543	324	350	51	571	15
16	Social Service	3,416	127	215	3,758	652	363	162	175	153	285	16
17	Nursing School	24,054	1,183	2,078	27,315	4,743	2,785	1,510	1,636	713	2,665	17
18	Intern-Resident Service	50,000	845	251	51,096	8,871	5,570	1,079	1,168	866	1,903	18
19	Organized Research	5,400	42		5,442	945	484	53	58	51	95	19
20	Fund Raising Acts.	16,407	126	322	16,855	2,926	1,452	162	175	102	285	20
	Special Service Cost Centers											
21	Operating Rooms	79,575	1,986	6,448	88,009	15,280	5,933	2,535	2,746	11,101	4,473	21
22	Delivery Rooms	10,408	845	716	11,969	2,078	726	1,079	1,168	3,157	1,903	22
23	Anesthesia	7,495		466	7,961	1,382	242			356		23
24	X-Ray	64,160	930	1,755	66,845	11,606	4,238	1,187	1,285	917	2,094	24
25	Laboratory	74,222	1,099	896	76,217	13,233	7,628	1,402	1,519	204	2,474	25
26	Blood Bank	6,895	169	430	7,494	1,301	363	216	234	51	381	26
27	Oxygen Therapy											27
28	Physical Therapy	60,917	549	788	62,254	10,809	5,448	701	759	1,324	1,237	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients		13,142	11,105	24,247	4,210		16,775	18,169	23,629	29,597	32
33	Nursery	5,673	1,310	286	7,269	1,262		1,672	1,811	3,361	2,950	33
	Outpatient Cost Centers											
34	Outpatients		2,789	394	3,183	553		3,560	3,856	815	6,281	34
35	Emergency	1,256	422	895	2,573	447	121	539	584	153	952	35
36	Private Ambulatory											36
37	TOTAL	$1774,466	$ 42,257	$ 35,823	$1774,466	$ 262,508	$121,081	$ 53,939	$ 58,417	$ 50,926	$ 95,164	37

FORM SSA-1562 (9-66)

Rev. 4

PROVIDER NO. 00-0000

PERIOD: 7/1/66 - 12/31/66

Worksheet B
First Apportionment

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2 thru 19)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a	57,928	63,812	81,740										1a
1b													1b
2			3,365									28,941	2
3			594									1,399	3
4			396									2,988	4
5			1,385									2,764	5
6			1,781									4,452	6
7			7,125									7,315	7
8	$		3,167									3,167	8
9		$											9
10	5,565		$										10
11			396	$ 53,194									11
12			35,822	5,373	$ 652,563								12
13			594		7,178	$ 31,237							13
14			792				$ 69,234						14
15			1,979		7,178			$42,781					15
16			198	537					$ 6,283				16
17			1,979	18,806	30,670					$92,822			17
18			4,156	27,403							$102,112		18
19												$ 7,128	19
20												21,957	20
21			4,156		51,553	3,905	8,377			9,839	19,197	227,104	21
22			594		22,187	2,936	3,739			8,633	13,989	74,158	22
23			198				9,485					19,624	23
24			3,167		24,797		2,562					118,698	24
25			5,542		29,366		1,454					139,039	25
26			198		5,220							15,458	26
27													27
28			3,958	1,075	14,357	1,593						103,515	28
29													29
30													30
32	52,165	63,812			343,250	20,022	35,378	35,081	6,283	62,840	67,599	803,057	32
33	198				33,932	1,031	2,839	428		7,054	1,327	65,134	33
34					72,434	94	2,215	5,989		3,992		102,972	34
35			198		10,441	1,656	3,185	1,283		464		22,596	35
36													36
37	$ 57,928	$ 63,812	$ 81,740	$ 53,194	$ 652,563	$ 31,237	$ 69,234	$ 42,781	$ 6,283	$ 92,822	$ 102,112	$ 1,774,466	37

DOUBLE APPORTIONMENT METHOD

EXHIBIT II-2

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-35)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 1a, and 1b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	LINE NO.
		1	1(a) BLDG. AND FIXTURES, ETC.	1(b) MOVABLE EQUIPMENT	2	3	4	5	6	7	8	
	General Service Cost Centers											
1a	Provision for Depreciation – Bldg. & Fixtures	$	$									1a
1b	Provision for Depreciation – Movable Equip.			$								1b
2	Administration & General				$ 28,941	$ 28,941						2
3	Employee Health & Welfare				4,399	73	$ 4,472					3
4	Operation of Plant				2,988	50	45	$ 3,083				4
5	Maintenance of Plant				2,764	46	111	20	$ 2,941			5
6	Laundry and Linen Service				4,452	74	111	91	88	$ 4,816		6
7	Housekeeping				7,315	121	297	7	7	10	$ 7,757	7
8	Dietary–Raw Food				3,167	52	197					8
9	–Other							96	92	37	250	9
10	Cafeteria							117	112	46	306	10
11	Maintenance of Personnel						15	615	590	142	1,608	11
12	Nursing Service						2,045	37	36	39	97	12
13	Medical Supplies & Expense						35	20	19	10	53	13
14	Pharmacy						40	17	16	5	44	14
15	Medical Records						106	20	19	5	53	15
16	Social Service						15	10	10	15	27	16
17	Nursing School						116	95	91	69	247	17
18	Intern-Resident Service						232	67	65	83	177	18
19	Organized Research				7,128	118	20	3	3	5	9	19
20	Fund Raising Activities				21,957	364	60	10	10	10	27	20
	Special Service Cost Centers											
21	Operating Rooms				227,104	3,766	247	159	152	1,069	415	21
22	Delivery Rooms				74,158	1,230	30	67	65	304	177	22
23	Anesthesia				19,624	325	10			34		23
24	X-Ray				118,698	1,968	176	74	71	88	194	24
25	Laboratory				139,039	2,305	317	88	84	20	230	25
26	Blood Bank				15,458	256	15	14	13	5	35	26
27	Oxygen Therapy											27
28	Physical Therapy				103,515	1,716	227	44	42	127	115	28
29	Cost of Medical Supplies Sold											29
30	Cost of Drugs Sold											30
	Inpatient Cost Centers											
32	Inpatients				803,057	13,315		1,050	1,009	2,276	2,748	32
33	Nursery				65,134	1,080		105	101	324	274	33
	Outpatient Cost Centers											
34	Outpatients				102,972	1,707		223	214	78	583	34
35	Emergency				22,596	375	5	34	32	15	88	35
36	Private Ambulatory											36
37	TOTAL	$	$	$	$1,774,466	$ 28,941	$ 4,472	$ 3,083	$ 2,941	$ 4,816	$ 7,757	37

FORM SSA-1562 (9-66)
23-34

Rev 1

PROVIDER NO. 00-0000

PERIOD: 7/1/66 - 12/31/66

Worksheet B
Second Apportionment

LINE NO.	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. 2 thru 19, Lines 21–37) (To Sched. C)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	20	
1a													1a
1b													1b
2													2
3													3
4													4
5													5
6													6
7													7
8	$ 3,416												8
9		$ 475											9
10	328		$ 909										10
11			6	$ 2,976									11
12			509	301	$ 3,064								12
13			8		34	$ 179							13
14			11				$ 133						14
15			28		34			$ 265					15
16			3	30					$ 110				16
17			28	1,052	144					$ 1,842			17
18			59	1,533							$ 2,216		18
19												$ 7,286	19
20												22,438	20
21			59		242	22	16			195	417	233,863	21
22			8		104	17	7			172	303	76,642	22
23			3				18					20,014	23
24			45		116		5					121,435	24
25			79		138		3					142,303	25
26			3		25							15,824	26
27													27
28			57	60	67	9						105,979	28
29													29
30													30
32	3,076	475			1,612	115	68	217	110	1,247	1,467	831,842	32
33	12				159	6	6	3		140	29	67,373	33
34					340	1	4	37		79		106,238	34
35			3		49	9	6	8		9		23,229	35
36													36
37	$ 3,416	$ 475	$ 909	$ 2,976	$ 3,064	$ 179	$ 133	$ 265	$ 110	$ 1,842	$ 2,216	$1,774,466	37

EXHIBIT II-3 DOUBLE APPORTIONMENT METHOD

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING Square Footage	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
		213,150	414,043		1,511,958	1,079,999	213,150	213,150	647,100	213,150	
	General Service Cost Centers										
1a	Provision for Depreciation: Bldg. & Fixtures										1a
1b	Provision for Depreciation: Movable Equip.										1b
2	Administration and General	14,493	23,185			100,444	14,493	14,493	2,592	14,493	2
3	Employee Health and Welfare	1,493	1,237		103,169	20,525	1,493	1,493	648	1,493	3
4	Operation of Plant	2,557	7,871		45,031	9,722	2,557	2,557	1,296	2,557	4
5	Maintenance of Plant	1,281	6,623		47,229	23,762	1,281	1,281	5,820	1,281	5
6	Laundry and Linen Service	5,755	6,207		38,538	23,762	5,755	5,755	1,296	5,755	6
7	Housekeeping	429	5,802		74,720	63,722	429	429	1,296	429	7
8	Dietary–Raw Food										8
9	–Other	6,042	8,010		68,731	18,954	6,042	6,042	4,956	6,042	9
10	Cafeteria	7,385	9,789		84,005	23,165	7,385	7,385	6,048	7,385	10
11	Maintenance of Personnel	38,794	5,802		11,237	3,238	38,794	38,794	18,768	38,794	11
12	Nursing Service	2,346	5,386		476,746	438,481	2,346	2,346	5,172	2,346	12
13	Medical Supplies and Expense	1,281	10,355		18,123	7,564	1,281	1,281	1,296	1,281	13
14	Pharmacy	1,064	5,802		56,563	8,643	1,064	1,064	648	1,064	14
15	Medical Records	1,281	5,386		25,379	22,683	1,281	1,281	648	1,281	15
16	Social Service	641	2,485		3,758	3,238	641	641	1,944	641	16
17	Nursing School	5,967	24,017		27,315	24,841	5,967	5,967	9,060	5,967	17
18	Intern-Resident Service	4,262	2,901		51,096	49,682	4,262	4,262	11,004	4,262	18
19	Organized Research	212			5,442	4,317	212	212	648	212	19
20	Fund Raising Activs.	636	3,722		16,855	12,951	636	636	1,296	636	20
	Special Service Cost Centers										
21	Operating Rooms	10,018	74,526		88,009	52,920	10,018	10,018	141,057	10,018	21
22	Delivery Rooms	4,262	8,276		11,969	6,476	4,262	4,262	40,115	4,262	22
23	Anesthesia		5,386		7,961	2,159			4,524		23
24	X-Ray	4,691	20,285		66,845	37,801	4,691	4,691	11,652	4,691	24
25	Laboratory	5,544	10,356		76,217	68,039	5,544	5,544	2,592	5,544	25
26	Blood Bank	852	4,970		7,494	3,238	852	852	648	852	26
27	Oxygen Therapy										27
28	Physical Therapy	2,769	9,108		62,254	48,594	2,769	2,769	16,824	2,769	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients	66,290	128,351		24,247		66,290	66,290	300,245	66,290	32
33	Nursery	6,608	3,306		7,269		6,608	6,608	42,707	6,608	33
	Outpatient Cost Centers										
34	Outpatients	14,068	4,554		3,183		14,068	14,068	10,356	14,068	34
35	Emergency	2,129	10,345		2,573	1,079	2,129	2,129	1,944	2,129	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$ 42,257	$ 35,823	$	$ 262,508	$ 121,081	$ 53,939	$ 58,417	$ 50,926	$ 95,164	37
38	Unit Cost Multiplier	.198250	.086520		.173621	.112112	.253057	.274065	.078699	.446465	38

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*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

Rev. 4

EXHIBIT II - 3

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Worksheet B-1
First Apportionment

LINE NO.	DIETARY RAW FOOD (Meals Served)	DIETARY OTHER (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
	1,143,475	1,143,475	91,467	99	413,263	18,071	53,387	100	7,046	88,982	61,175	
1a												1a
1b												1b
2			3,765									2
3			664									3
4			443									4
5			1,560									5
6			1,993									6
7			7,973									7
8			3,544									8
9												9
10	109,851											10
11			433									11
12			40,089	10								12
13			664		4,546							13
14			886									14
15			2,214		4,546							15
16			221	1								16
17			2,214	35	19,423							17
18			4,651	51								18
19												19
20												20
21			4,651		32,648	2,259	6,460			9,432	11,501	21
22			664		14,051	1,699	2,883			8,276	8,381	22
23			221				7,314					23
24			3,544		15,704		1,976					24
25			6,202		18,597		1,121					25
26			221		3,306							26
27												27
28			4,429	2	9,092	922						28
29												29
30												30
32	1,029,716	1,143,475			217,377	11,583	27,280	82	7,046	60,240	40,498	32
33	3,908				21,489	596	2,189	1		6,763	795	33
34					45,872	54	1,708	14		3,826		34
35			221		6,612	958	2,456	3		445		35
36												36
37	$ 57,928	$ 63,812	$ 81,740	$ 53,194	$ 652,563	$ 31,237	$ 69,234	$ 42,781	$ 6,283	$ 92,822	$ 102,112	37
38	.050660	.055805	.89366	537.313131	1.579050	1.728571	1.296833	427.81	.891712	1.043155	1.669178	38

EXHIBIT II-4 DOUBLE APPORTIONMENT METHOD

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Cost*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING Square Footage	LINE NO.
		1(a)	1(b)	2	3	4	5	6	7	8	
	General Service Cost Centers				1,745,525	959,031	194,607	193,326	635,448	187,142	
1a	Provision for Depreciation: Bldg. & Fixtures										1a
1b	Provision for Depreciation: Movable Equip.										1b
2	Administration and General				1,745,525						2
3	Employee Health and Welfare				4,399	959,031					3
4	Operation of Plant				2,988	9,722	194,607				4
5	Maintenance of Plant				2,764	23,762	1,281	193,326			5
6	Laundry and Linen Service				4,452	23,762	5,755	5,755	635,448		6
7	Housekeeping				7,315	63,722	429	429	1,296	187,142	7
8	Dietary—Raw Food				3,167	42,119					8
9	—Other						6,042	6,042	4,956	6,042	9
10	Cafeteria						7,385	7,385	6,048	7,385	10
11	Maintenance of Personnel					3,238	38,794	38,794	18,768	38,794	11
12	Nursing Service					438,481	2,346	2,346	5,172	2,346	12
13	Medical Supplies and Expense					7,564	1,281	1,281	1,296	1,281	13
14	Pharmacy					8,643	1,064	1,064	648	1,064	14
15	Medical Records					22,683	1,281	1,281	648	1,281	15
16	Social Service					3,238	641	641	1,944	641	16
17	Nursing School					24,841	5,967	5,967	9,060	5,967	17
18	Intern-Resident Service					49,682	4,262	4,262	11,004	4,262	18
19	Organized Research				7,128	4,317	212	212	648	212	19
20	Fund Raising Activities				21,957	12,951	636	636	1,296	636	20
	Special Service Cost Centers										
21	Operating Rooms				227,104	52,920	10,018	10,018	141,057	10,018	21
22	Delivery Rooms				74,158	6,476	4,262	4,262	40,115	4,262	22
23	Anesthesia				19,624	2,159			4,524		23
24	X-Ray				118,698	37,801	4,691	4,691	11,652	4,691	24
25	Laboratory				139,039	68,039	5,544	5,544	2,592	5,544	25
26	Blood Bank				15,458	3,238	852	852	648	852	26
27	Oxygen Therapy										27
28	Physical Therapy				103,515	48,594	2,769	2,769	16,824	2,769	28
29	Cost of Medical Supplies Sold										29
30	Cost of Drugs Sold										30
	Inpatient Cost Centers										
32	Inpatients				803,057		66,290	66,290	300,245	66,290	32
33	Nursery				65,134		6,608	6,608	42,707	6,608	33
	Outpatient Cost Centers										
34	Outpatients				102,972		14,068	14,068	10,356	14,068	34
35	Emergency				22,596	1,079	2,129	2,129	1,944	2,129	35
36	Private Ambulatory										36
37	Cost to be apportioned (per W/S B)	$	$	$	$ 28,941	$ 4,472	$ 3,083	$ 2,941	$ 4,816	$ 7,757	37
38	Unit Cost Multiplier				.016580	.004663	.015842	.015213	.007579	.041449	38

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*Total Accumulated Costs of all other cost centers, per col. 2, lines 3 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

Rev 4

PROVIDER NO. 00-0000 EXHIBIT II-4

PERIOD 7/1/66 - 12/31/66

Worksheet B-1
Second Apportionment

LINE NO.	DIETARY RAW FOOD (Meals Served)	DIETARY OTHER (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req's)	PHARMACY (Costed Req's)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
	9	10	11	12	13	14	15	16	17	18	19	
	1,143,475	1,143,475	89,422	99	413,263	18,071	53,387	100	7,046	88,982	61,175	
1a												1a
1b												1b
2												2
3												3
4												4
5												5
6												6
7												7
8	1,143,475											8
9		1,143,475										9
10	109,851		89,422									10
11			554	99								11
12			50,111	10	413,263							12
13			831		4,546	18,071						13
14			1,107				53,387					14
15			2,768		4,546			100				15
16			277	1					7,046			16
17			2,768	35	19,423					88,982		17
18			5,813	51							61,175	18
19												19
20												20
21			5,813		32,648	2,259	6,460			9,432	11,501	21
22			831		14,051	1,699	2,883			8,276	8,381	22
23			277				7,314					23
24			4,430		15,704		1,976					24
25			7,752		18,597		1,121					25
26			277		3,306							26
27												27
28			5,536	2	9,092	922						28
29												29
30												30
32	1,029,716	1,143,475			217,377	11,583	27,280	82	7,046	60,240	40,498	32
33	3,908				21,489	596	2,189	1		6,763	795	33
34					45,872	54	1,708	14		3,826		34
35			277		6,612	958	2,456	3		445		35
36												36
37	$ 3,416	$ 475	$ 909	$ 2,976	$ 3,064	$ 179	$ 133	$ 265	$ 110	$ 1,842	$ 2,216	37
38	.002987	.000415	.01016	30.060606	.007414	.009905	.002491	2.650000	.015612	.020700	.036224	38

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS) PERIOD: 7/1/66 to 12/31/66 PROVIDER NO. 00-0000 EXHIBIT III

CLASSIFICATION AND ADJUSTMENT OF HOSPITAL OPERATING EXPENSES (Omit Cents)

EXPENSE CLASSIFICATION	EXPENSES PER BOOKS	ADJUSTMENTS *Increases and (Decreases) (See page 2a)*	ADJUSTED OPERATING EXPENSES	INPATIENT EXPENSES	OUTPATIENT EXPENSES
	1	2	3	4	5
1. Administration and General	$ 328,389	$ (2,782)	$ 325,607	$	$
2. Dietary	172,356	(18,149)(5,673)	148,534	148,534	
3. Housekeeping	74,133		74,133		
4. Laundry	36,860		36,860		
5. Linen Service					
6. Maintenance of Personnel	4,681	(1,637)	3,044		
7. Operation of Plant	90,245		90,245		
8. Motor Service					
9. Repairs and Maintenance					
10. Nursing Service	475,815		475,815		
11. Nursing Education	29,482	(5,428)	24,054		
12. Medical & Surgical Service					
13. Interns, Residents, & Physicians		50,000	50,000		
14. Other Services and Supplies	69,359	(52,386)	16,973		
15. Pharmacy	55,850		55,850	51,940	3,910
16. Medical Records and Library	25,956	(1,297)	24,659		
17. Social Service	3,416		3,416	3,416	
18. Operating Rooms	79,575		79,575	73,607	5,968
19. Delivery Rooms	10,408		10,408	10,408	
20. Anesthesiology	7,495		7,495	6,933	562
21. X-ray	88,768	(24,608)	64,160	57,098	7,062
22. Laboratory	100,599	(26,377)	74,222	68,655	5,567
23. Basal Metabolism					
24. Electrocardiology					
25. Physical Therapy	60,917		60,917	56,348	4,569
26. Ambulance	5,907		5,907	5,907	
27. Inhalation Therapy					
28. Occupational Therapy					
29. Electroencephalography					
30. Blood Bank		6,895	6,895	6,895	
31. Postoperative Recovery Room					
32. Central Sterile Supply					
33. Outpatient Services					
34. Provision for Depreciation	78,080		78,080		
35. Interest Expense					
36. Rent of Land and Buildings					
37. Property Taxes					
38. Fund Raising Expenses					
39. Research (Organized)	5,400		5,400	5,400	
40. Nursery (Food)		5,673	5,673	5,673	
41. Fund Raising Activities	10,500		10,500	10,500	
42. Emergency	1,256		1,256		1,256
43. Subtotal	1,815,447	(75,769)	1,739,678	511,314	28,894
44. Indirect Costs Distributed*				1,135,310	64,160
45.					
46.					
47. Amt. not eligible for reim.		(33,288)	(33,288)	(33,288)	
48. Total	$ 1,815,447	$ (109,057)	$1,706,390	$1,613,336	$ 93,054
49. 2% allowance in lieu of specific recognition of other costs (A)			34,128	32,267	1,861
50. TOTALS			$1,740,518	$1,645,603	$ 94,915

FORM SSA-1564 (9-66) (A) Show computation on Form SSA-1563A 1a

* Sum of lines 1,3,4,6,7,10,11,13,14,16, and 34. See computation #2 Exhibit III-2.

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS) EXHIBIT III - 1

PROVIDER NO 00-0000

PERIOD 7/1/66 to 12/31/66

ADJUSTMENTS TO EXPENSES (Omit Cents)

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT *	AMOUNT	EXPENSE CLASSIFICATION ON PAGE 1A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin. & Gen.	1
2.	Radio and television service	B	(594)	Admin. & Gen.	1
3.	Laundry and Linen Service				4 & 5
4.	Vending Machines Commission				7
5.	Employee and guest meals	B	(18,149)	Dietary	2
6.	Sale of drugs to other than patients				15
7.	Sale of medical and surgical supplies to other than patients				14
8.	Sale of medical records and abstracts	B	(1,297)	Medical Records	16
9.	Sale of scrap, waste, etc.	B	(1,484)	Admin. & Gen.	1
10.	Rental of quarters to employees and others	B	(1,637)	Maint. of Personnel	6
11.	Rental of hospital space				7
12.	Payments received from specialists				1
13.	Trade, quantity, time, and other discounts on purchases	B	(2,386)	Med.Supplies & Expenses	14
14.	Rebates and refunds of expenses				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				35
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	Nursing School	11
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	22 Various
21.	Fund raising expenses				Various
22.	Depreciation				34
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	TOTAL		$ (75,769)		

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*BASIS FOR ADJUSTMENT: A – Cost B – Amount Received

COMBINATION METHOD (ESTIMATED PERCENTAGE BASIS)

EXHIBIT III - 2

Provider No. 00-0000

Period

7/1/66 - 12/31/66

CALCULATION FOR GENERAL SERVICE COSTS
APPLICABLE TO NONALLOWABLE COST CENTERS

COMPUTATION #1

Subtotaled Costs (Line 43, Col. 3)		$1,739,678
Less: Overhead accounts included in the total - Exhibit III	(A)	600,000
Base for computation of rate	(B)	$1,139,678

Computation of Rate $\frac{(A)}{(B)} = \frac{\$\ 600,000}{\$1,139,678} = 52.646\%$

Nonreimbursable Costs:	
Organized Research	$ 5,400
Fund Raising Activities	10,500
Ambulance	5,907
Total	$21,807
$21,807 times 52.646% =	11,481
Amount not eligible for reimbursement	$33,288

CALCULATION FOR ALLOCATING INDIRECT COSTS

COMPUTATION #2

Amount (Line 43, Col. 3)		$1,739,678
Less:		
Inpatient Expenses (Line 43, Col. 4)	$511,314	
Outpatient Expenses (Line 43, Col. 5)	28,894	540,208
Amount to be distributed		$1,199,470

Distribution:

	Direct Costs	Percent to Total	Indirect Costs Distributed
Inpatient Expenses	$511,314	94.651%	$1,135,310
Outpatient Expenses	28,894	5.349	64,160
	$540,208	100.000%	$1,199,470

NATIONAL LEAGUE FOR NURSING - METHOD I

EXHIBIT IV

PROVIDER NO. 00-7000

TOTAL OPERATING COSTS

SCHEDULE A-3

PERIOD ENDING YE 6/30/67

	HOME HEALTH AGENCY COST FROM RECORDS A	ADJUSTMENT TO COSTS (See Schedule A-3a) B	HOME HEALTH AGENCY ADJUSTED COSTS NET (Col. A & Col. B) C
1. SALARY COSTS (Salaries plus agency costs for retirement, social security, health insurance, other employee benefits.)			
(a) Director and administrative assistant	$ 7,000	$	
(b) Consultants	--		
(c) Supervisors	--		
(d) Professional nurses providing generalized services	29,400		
(e) Specialists – PT, OT, ST	6,950		
(f) Practical nurses	9,600		
(g) Home Health Aides	7,645		
(h) Clerical staff	8,105		
(i) Other (Specify)	--		$ 68,700
2. TRANSPORTATION COSTS			
(a) Automobile operating costs	$ 1,956	$	
(b) Automobile insurance	2,100	(200)	
(c) Automobile depreciation (Furnish details)	1,350		
(d) Gains or Losses on sale or disposition of automobiles	--		
(e) Other (Specify) (Public Transportation)	24		
(f) Automobile allowances paid to staff members	950		6,180
3. SERVICES PURCHASED FROM OTHER AGENCIES OR UNDER ARRANGEMENTS. (Contract Services)	-- $	$	--
4. MEDICAL AND NURSING SUPPLIES (Including non depreciable equipment)	$ 840	$ (206)	634
5. SPACE OCCUPANCY COSTS			
(a) Rent	$ 3,900	$	
(b) Heat and light	790		
(c) Maintenance and repairs	923	(800)	
(d) Taxes	--		
(e) Depreciation if building owned or donated (Furnish details)	--		
(f) Other (Specify)	--		4,813
6. OFFICE COSTS			
(a) Stationery and Printing	$ 440	$	
(b) Telephone and telegraph	875		
(c) Postage and express	180		
(d) Other (Specify) (Office Equipment Rental)	200		1,695
7. OTHER GENERAL COSTS			
(a) Depreciation on furniture and equipment (Furnish details)	$ 240	$ 120	
(b) Dues and subscriptions	25		
(c) Legal and accounting fees	100		
(d) Laundry	--		
(e) Inservice and Staff Education	--		
(f) Insurance (Other than automobile)	440		
(g) Cost of rental equipment furnished to patients (See instructions)	--		
(h) Other (Specify) (Sundry)	42		967
8. COST FOR SPACE OCCUPANCY, OFFICE AND OTHER GENERAL COSTS, FRINGE BENEFITS, ETC. NOT IDENTIFIABLE AND NOT INCLUDED IN ITEMS 1 THRU 7	$ --	$ --	--
9. SUBTOTAL ITEMS 1–8	$ 84,075	$ (1,086)	$ 82,989
10. ADD ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS (2% non profit) (1½% proprietary) OF LINE 9 COL. (c)			1,660
11. INTEREST	$ 142	$	142
12. RETURN ON EQUITY CAPITAL (Proprietary providers only)	$ --	$	--
13. TOTAL COSTS (Items 9 to 12)			$ 84,791

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EXHIBIT IV - 1
PROVIDER NO. 00-7000

ADJUSTMENTS TO EXPENSES *(Omit Cents)*

SCHEDULE A-3a
PERIOD ENDING
YE 6/30/67

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT*	AMOUNT	EXPENSE CLASSIFICATION ON PAGE 3, SCH. A-3, FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Trade, quantity, time and other discounts on purchases		$		
2.	Rebates and refunds of costs	B	(200)	Automobile Insurance	Various
3.	Amount applicable to Part B for physicians services				Various
4.	Fund raising costs				Various
5.	A "Meals on Wheels" program				
6.	Grants, gifts and income designated by the donor for specific expenses				Various
7.	Interest on unrestricted funds				
8.	Sale of medical and nursing supplies to other than patients	B	(206)	Medical and Nursing Supplies	
9.	Sale of drugs to patients				
10.	Capital items included in costs	A	(800)	Repairs and Maintenance	
11.	Tuition fee received				
12.	Depreciation *(Furnish Details)*		120	Depreciation on Furniture and Fixtures	
13.					
14.					
15.	TOTAL		$ (1,086)		

* Basis for adjustment
A—Cost B—Amount Received C—Estimate

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Rev. 4

EXHIBIT IV - 2

PROVIDER NO. 00-7000

COMPUTATION OF COST PER VISIT FOR AGENCY USING AVERAGE COST PER VISIT BASIS AND AVERAGE HOURLY COST FOR HOME HEALTH AIDES

SCHEDULE A-4

PERIOD ENDING YE 6/30/67

1.	Allowable costs from page, 3, Sch. A-3, Col. C. line 13	$ 84,791
2.	Less: Costs allocated to Home Health Aide visits *(Enter on line 7)*	11,487
3.	Net costs for visits *(Line 1, less line 2)*	$ 73,304
4.	Less: Deduction for non-visiting costs *(Sch. A-5)* Col. D., line 10	6,152
5.	Costs of visits, other than aides *(Enter on line 6)*	$ 67,152

6. Visit Costs (Other than aides) $ 67,152 ÷ Number of Visits* (Other than aides) 8,490 = Average Cost Per Visit (Include cents) $ 7.91

7. Home Health Aide Costs $ 11,487 ÷ Number of Hours/Visits Home Health Aides 1,430 = Average Cost Per Hour/Visit (Include cents) $ 8.03

* A visit is defined according to the definition listed in "Conditions of Participation for Home Health Agencies" publication HIM-2(3-66) U.S. Dept. of HEW, Social Security Administration. Do not include "Not home – not found," as a visit

DETERMINATION OF NON-VISITING COSTS

SCHEDULE A-5

Item A		Item B		Item C
Time spent on staff level in non-visiting activities including related office and travel time. 940 hours	÷	Total working time on staff level Minus time spent in community activity and staff education 11,750 hours	=	Percent not chargeable to the cost of making visits *(correct to first decimal)* 8.0 %

Item D Deduct 8.0 % for non-visiting costs. *(Apply percentage to Col. C costs where applicable and insert applicable amount in Col. D)*

	COSTS *(From Page 3 Sch. A-3 Col. C)*	TOTAL A	COSTS ALLOCATED FOR H.H. AIDES B	NET COSTS *(A minus B)* C	DEDUCTIONS D
1.	Salaries	$ 68,700	$ 9,799	$ 58,901	$ 4,712
2.	Transportation	6,180	360	5,820	465
3.	"Contract Services"	--			
4.	Medical and Nursing Supplies	634			
5.	Space Occupancy Costs	4,813	1,328	8,583	975
6.	Office Costs	1,695			
7.	Other General Costs	967			
8.	Costs Not Identifiable *(Not included in items 1-7)*	--			
9.	Misc. Costs – Includes items 10, 11, 12 of Schedule A-3	1,802			
10.	TOTAL	$ 84,791	$ 11,487	$ 73,304	$ 6,152
		Agrees with page 3, sch. A-3 Col. C, line 13	*Enter on line 2 sch. A-4 above*	*Agrees with line 3 sch. A-4 above*	*Enter on line 4 sch. A-4 above*

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SCHEDULE A-4 - HOME HEALTH AIDE COSTS

Total salaries	$68,700		
Less salary of director and clerical	15,105		
	$53,595		
Home Health Aides Salary	$ 7,645		
Percentage	14.26%		
Home Health Aide Costs --			
Salaries			$ 7,645
Transportation			360
Portion of indirect costs --			
Total Cost		$84,791	
Less-Direct Salaries	$53,595		
Transportation	6,180		
Rent Expense Applicable to Nonvisiting Activities	600	60,375	
		$24,416	
Percentage shown above		14.26%	3,482
			$11,487

SCHEDULE A-5 - TOTAL WORKING TIME ON STAFF LEVEL

Number of nurses on staff	6
Number of days worked by each nurse	250
Total nurse days in year	1,500
Total staff hours in year (1500 x 8)	12,000
Less time spent on staff education and community activities	250
	11,750

SCHEDULE A-5 - COMPUTATION OF NONVISITING COSTS FOR LINES 3 TO 9

Total of lines 3 to 9, column C		$8,583
Less space occupancy rent applicable to		
Visiting activities	$3,300	
Non-visiting activities	600	3,900
		$4,683
% nonvisiting costs		8%
		$ 375
Add rent for nonvisiting activities		600
Total of lines 3 to 9, column D		$ 975

PROVIDER NO. 00-7000

CALCULATION OF REIMBURSABLE COST OF HOME HEALTH SERVICES

SCHEDULE A-1

PERIOD ENDING YE 6-30-67

LINE NO.	TYPE OF VISITS	AVERAGE COST PER VISIT (Include cents)	POST HOSPITAL PLAN PART A		MEDICAL PLAN PART B	
			NO. OF VISITS	COSTS (Omit cents)	NO. OF VISITS	COSTS (Omit cents)
1.	All Visits Combined	$ 7.91	360	$ 2,848	1,050	$ 8,306
2.	Skilled Nursing Care					
3.	Physical Therapy					
4.	Speech Therapy					
5.	Occupational Therapy					
6.	Medical Social Services					
7.	Other Covered Visits (Specify)					
8.	Home Health Aide — NUMBER OF HOURS: PART A / PART B	UNIT COST: per visit $ 8.03			350	2,811
9.	Cost of Rental Equipment					
10.	TOTAL COST INCURRED (Items 1 thru 9) OR TOTAL COST (Sch. A-9 line 8)			$ 2,848		$ 11,117
11.	Less: Deductibles chargeable to Health Insurance Program Patients					900
12.	Net Cost (Line 10 less line 11)			$ 2,848		$ 10,217
13.	80% of Net Cost (Line 12, part B) applicable to Health Insurance Program					$ 8,174
14.	Less payments made or to be made by intermediary/SSA for period (Exclude current financing)			2,160		6,000
15.	Balance due Home Health Agency/Intermediary exclusive of bad debts			688		$ 2,174
16.	Total reimbursable bad debts (Schedule A-2 line 10)					300
17.	Total amount due Home Health Agency/Health Insurance Program (Sum of lines 15 and 16)			$ 688		$ 2,474

REIMBURSABLE BAD DEBTS (Applicable to Part B only)

SCHEDULE A-2

1.	Total Home Health costs applicable to Part B of Health Insurance Program (Schedule A-1, Line 10, Part B)	$ 11,117
2.	Less amount received or to be received from Intermediary or Social Security Administration (Schedule A-1, Line 14 plus Line 15)	8,174
3.	Balance to be recovered from HI Program home health patients (Line 1 minus line 2)	$ 2,943
4.	Deductibles and coinsurance billed to HI Program home health patients	$ 2,400
5.	Less: Bad debts for deductibles and coinsurance	300
6.	Net deductibles and coinsurance billed to HI Program home health patients	$ 2,100
7.	Unrecovered from HI Program patients (Line 3 less line 6). If line 6 is greater than line 3 enter zero on lines 7 and 8. (Complete line 7 only when line 3 exceeds line 6.)	$ 843
8.	Reimbursable bad debts—current period—lower of line 5 or line 7	$ 300
9.	Add or subtract bad debts NET of recoveries for prior periods reported	- 0 -
10.	Total reimbursable bad debts (Sum of lines 8 and 9) (Enter on schedule A-1 line 16)	$ 300

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EXHIBIT IV - 7

PROVIDER NO. 00-7000

CALCULATION OF REIMBURSABLE COST OF HOSPITAL BASED HOME HEALTH SERVICES BASED ON RCCAC APPORTIONMENT

SCHEDULE A-1

PERIOD YE 6-30-67

	RATIO OF CHARGES TO CHARGES APPLIED TO COST *(Omit Cents)*	POST HOSPITAL PLAN *(Part A)*	MEDICAL PLAN *(Part B)*
1.	Total amount of home health charges *(gross)* all patients *(Use same amount in both columns)*	$ 58,440	$ 58,440
2.	Total amount of patient charges *(gross)* Health Insurance Program	$ 2,160	$ 8,400
3.	Percent Health Insurance Program charges to total gross charges *(Line 2 divided by line 1 rounded to the first decimal place)*	3.7 %	14.4 %
4.	Total cost of home health services *(From Form SSA-1562, Schedules B) (Use same amount in both columns)*	$ 84,791	$ 84,791
5.	Less: Cost of non-covered services for which no charge is made on line 1 above per schedule A-3 page 3 – Line 10. *(Use same amount in both columns)*	6,152	6,152
6.	Total cost of home health services for which charges have been made *(Line 4 less line 5) (Use same amount in both columns)*	$ 78,639	$ 78,639
7.	Percent applicable to Health Insurance Program – *(Line 3 above)*	3.7 %	14.4 %
8.	Total cost applicable to Health Insurance Program *(Line 6 multiplied by line 7)*	$ 2,910	$ 11,324
9.	Less: Deductibles billed to Health Insurance patients		900
10.	Net Cost *(Line 8 less line 9)*	$ 2,910	$ 10,424
11.	80% of net cost *(Line 10)* applicable to Health Insurance Program		$ 8,339
12.	Less: Payments made or to be made by intermediary or SSA for the period *(Exclude current financing)*	$ 2,160	$ 6,000
13.	Balance due Home Health Agency/Health Insurance Program exclusive of bad debts *(Part A line 10 less line 12) (Part B – Line 11 less line 12)*	$ 750	$ 2,339
14.	Total reimbursable bad debts *(Schedule A-2 line 10)*		$ 300
15.	Total amount due Home Health Agency/Health Insurance Program for Part A and Part B services *(Line 13 plus line 14)*	$ 750	$ 2,639

REIMBURSABLE BAD DEBTS (Applicable to Part B only)

SCHEDULE A-2

1.	Total home health costs applicable to part B of Health Insurance Program *(Line 8–Part-B–Schedule A-1)*	$ 11,324
2.	Less: Amount received or to be received from Intermediary or Social Security Administration *(Line 12 plus line 13–Schedule A-1)*	8,339
3.	Balance to be recovered from HI Program home health patients	$ 2,985
4.	Deductibles and coinsurance billed to HI Program Home Health Patients	$ 2,400
5.	Less: Uncollectible deductibles and coinsurance amounts	300
6.	Net deductibles and coinsurance billed to HI Program Home Health Patients *(Line 4 less line 5)*	$ 2,100
7.	Unrecovered from HI Program Patients *(Line 3 less Line 6)* If line 6 is greater than line 3 enter zero on lines 7 and 8; *(If line 3 is greater than line 6, enter the difference here)*	$ 885
8.	Reimbursable bad debts for current period – lesser of line 5 or line 7	$ 300
9.	Add or subtract reimbursable bad debts net of recoveries for prior periods reported	- 0 -
10.	Total Reimbursable Bad Debts *(Sum of lines 8 and 9) (Enter on Schedule A-1 Line 14)*	$ 300

EXHIBIT V - 1

PROVIDER NO. 00-7000

COMPUTATION OF AVERAGE COST PER VISIT BASED ON COST CENTER-STAFF NURSING ONLY

SCHEDULE A-6

PERIOD ENDING YE 6/30/67

COMPUTATION OF COST PER VISIT FOR YEAR

	TYPE OF EXPENSE	NUMBER OF HOURS		COST PER HOUR	COST		
		VISITING	ALL OTHER SERVICE		VISITING	ALL OTHER SERVICE	TOTAL
1.	SALARY FOR DIRECT SERVICE Staff Nurse	10,810	940	$ 3.25	$ 35,132	$ 3,055	$ 38,187
2.	Supervisor						
3.	Physical Therapist	900	100	6.95	6,255	695	6,950
4.	Home Health Aide	4,000	--	1.92	7,645	--	7,645
5.	Contracted Services						
6.							
7.	Cost of supervision						
8.	Cost of consultation service						
9.	Cost of transportation				6,180	--	6,180
10.	Direct allocations of expense				3,300	600	3,900
11.	Overhead cost				17,527	1,524	19,051
	12. Sum of above factors				76,039	5,874	81,913
	13. Pro rata share of staff education and community activities				1,133	85	1,218
	14. Allowance in lieu of specific recognition of other costs				1,544	116	1,660
	15. Total Cost				$ 78,716	$ 6,075	$ 84,791
	16. Number of Visits				9,920		Per EXHIBIT IV
	17. Cost per Visit *(Line 15 divided by line 16)* Enter on Sch. A-1 or Complete Sch. A-7 for each discipline				$ 7.94		

COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Skilled Nursing		SCHEDULE A-7
1.	1.487 (A) hours of Staff nurse @ $3.25 (B) per hour	$ 4.833
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $5280 ÷ 7,270 visits	.726
5.	Overhead cost of 1.487 hours @ $ 1.115 (C) per hour	1.658
5A	Direct Allocation (Rent) ($3300 ÷ 9920 visits)	.333
	Subtotal	7.550
6.	Pro Rata share of costs of staff education and participation in community activities @ $.0149 per dollar ($1218 ÷ $81,913)	.113
	Subtotal	7.663
7.	Allowance in lieu of specific recognition of other costs (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $7.663	.153
8.	TOTAL COST PER VISIT	$ 7.816

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

(A) $\frac{10,810 \text{ hrs}}{7,270 \text{ visits}} = 1.487 \text{ hours}$

(B) $\frac{\$39,000}{12,000 \text{ hours}} = \$3.25$

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hrs.

(C) $\frac{\$17,527 \text{ overhead costs}}{15,710 \text{ hrs.}} = \$1.115$ per hour

NATIONAL LEAGUE FOR NURSING - METHOD II

EXHIBIT V-3

COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Physical Therapy		SCHEDULE A-7
1.	.738 (A) hours of Staff nurse @ $ 6.95 (B) per hour	$ 5.129
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $540 ÷ 1220 visits	.443
5.	Overhead cost of .738 hours @ $ 1.115 (C) per hour	.823
5A	Direct allocation (Rent) ($3300 ÷ 9920 visits)	.333
6.	Pro Rata share of costs of staff education and participation in Subtotal	6.728
	community activities @ $.0149 per dollar $1218 ÷ 81913	.100
7.	Allowance in lieu of specific recognition of other costs Subtotal (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $6.828	6.828 .137
8.	TOTAL COST PER VISIT	$ 6.965

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

(A) $\frac{900 \text{ hours}}{1{,}220 \text{ visits}} = .738 \text{ hours}$

(B) $\frac{\$6{,}950}{1{,}000 \text{ hours}} = \$6.95$

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hours

(C) $\frac{\$17{,}527 \text{ overhead costs}}{15{,}710 \text{ hours}} = \$1.115$ per hour

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COMPUTATION OF COST PER VISIT BY DISCIPLINE* (Specify) Home Health Aides		SCHEDULE A-7
1.	2.797 (A) hours of Staff nurse @ $ 1.90 per hour	$ 5.314
2.	Supervision of _____ hours of staff nurse @ $ _____ per hour	
3.	Consultation service for _____ hours of staff nurse @ $ _____ per hour	
4.	Transportation cost per trip $360 ÷ 1430 visits	.252
5.	Overhead cost of 2.797 hours @ $ 1.115 (C) per hour	3.119
5A	Direct Allocation (Rent) $3300 ÷ 9,920 visits	.333
6.	Pro Rata share of costs of staff education and participation in Subtotal	9.018
	community activities @ $.0149 per dollar $1218 ÷ 81,913	.134
7.	Subtotal Allowance in lieu of specific recognition of other costs (2% non-profit) (1½% proprietary) of sum of lines 1 thru 6 2% of $9.152	9.152 .183
8.	TOTAL COST PER VISIT	$ 9.335

*Similar schedule for each type of service provided such as physical therapy, medical social services, etc. must be completed.

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(A) $\frac{4000 \text{ hours}}{1430 \text{ visits}}$ = 2.797 hours

Direct Service Hours

Nurses	10,810
Physical Therapy	900
Home Health Aides	4,000
	15,710 hours

(B) $\frac{\$7,645}{4,000 \text{ hours}}$ = $1.90 per hour

(C) $\frac{\$17,527 \text{ overhead cost}}{15,710 \text{ hours}}$ = $1.115 per hour

SCHEDULE A-7, SUMMARY OF SKILLED NURSING, PHYSICAL THERAPY, AND HOME HEALTH AIDES

Skilled nursing	$7.929 x 7,270 VTS. =	$57,644
Physical therapy	$7.942 x 1,220 VTS. =	9,689
Home health aides	$7.936 x 1,430 VTS. =	11,348
Total		$78,681
Rounding differences		35
Total per Schedule A-6, line 15		$78,716

EXHIBIT VI

PROVIDER NO. 00-7000

ALLOCATION OF OPERATING COSTS AND CALCULATION OF COST PER VISITS

SCHEDULE A-8

PERIOD ENDING YE 6/30/67

	CLASSIFICATION OF COSTS	TOTAL AGENCY COSTS (Omit cents)	UNIDENTIFIED TO SPECIFIC DISCIPLINE	COSTS IDENTIFIABLE TO SPECIFIC DISCIPLINE OR PROGRAM AREA						
				SKILLED NURSING CARE	PHYSICAL THERAPY	SPEECH THERAPY	OCCUPATIONAL THERAPY	MEDICAL SOCIAL SERVICES	HOME HEALTH AIDES	OTHER (Specify)
		A	B	C	D	E	F	G	H	I
1.	Salaries	$ 53,595	$	$ 39,000	$ 6,950	$	$	$	$ 7,645	$
2.	Transportation Costs	6,180	--	5,280	540				360	
3.	Contracted Services	--	--							
4.	Medical and Nursing Supplies	634	634							
5.	Space Occupancy Costs	4,813	4,813							
6.	Office Costs	1,695	1,695							
7.	Other General Expense Costs	967	967							
8.	Other costs not included in Items 1–7 Sch. A-3, Item 8	--	--							
9.	Misc. Costs Sch. A-3 Items 10, 11, 12	1,802	1,802							
10.	Total Costs (excluding salaries) sum of lines 2–9	$ 16,091	$ 9,911	$ 5,280	$ 540	$	$	$	$ 360	$
11.	Amount of unidentified costs to be charged to each discipline. Apply ratio in Line 11 Col. B to Line 1 on each column.	To calculate percent divide Col. B Line 10 by Col. A Line 1.	.1849 %	7,212	1,285				1,414	
12.	**Administrative Salaries to be Allocated** / Salaries of all other personnel to be allocated	$ 15,105 / $ 53,595	.2818 % Apply ratio to Line 1 of each column	10,991	1,959				2,155	
13.	**Total Costs for each discipline** *(Sum of Items 1, 10, 11 and 12)*			$ 62,483	$ 10,734	$	$	$	$ 11,574	$
14.	Percent of Time spent during Reporting Period			92.0 %	90.0 %	%	%	%	100.0 %	%
15.	Home Visits – Disease or Disability *(Multiply line 13 by line 14)*			$ 57,484	$ 9,661	$	$	$	$ 11,574	$
16.	Number of Home Visits – Disease or Disability Made during Reporting Period			7,270	1,220				1,430	
17.	Cost of Home Visits – Disease or Disability *(Divide line 15 by line 16 – Transfer Result to A-1, Lines 2-8)*			$ 7.91	$ 7.92	$	$	$	$ 8.09	$

Rev. 4

FORM SSA-1728 (7-67)

273-003 O - 67

EXHIBIT VII

PROVIDER NO. 00-7000

CALCULATION OF HI PROGRAM COST OF HOME HEALTH SERVICES BASED ON RCCAC APPORTIONMENT

SCHEDULE A-9

PERIOD ENDING YE 6/30/67

RATIO OF CHARGES TO CHARGES APPLIED TO COST *(Omit Cents)*	POST HOSPITAL PLAN *(Part A)*	MEDICAL PLAN *(Part B)*
1. Total amount of home health charges *(gross)* all patients *(Use same amount in both columns)*	$ 58,440	$ 58,440
2. Total amount of patient charges *(gross)* Health Insurance Program	$ 2,160(1)	$ 8,400(2)
3. Percent Health Insurance Program charges to total gross charges *(Line 2 divided by line 1)* rounded to first decimal place	3.7 %	14.4
4. Total cost of home health services *(Schedule A-3) (Use same amount in both columns)*	$ 84,791	$ 84,791
5. Less: Cost of non-covered services for which no charge is made on line 1 above per schedule A-10, Line 10 *(Use same amount in both columns)*	6,152	6,152
6. Total cost of home health services for which charges have been made *(Line 4 less line 5) (Use same amount in both columns)*	$ 78,639	$ 78,639
7. Percent applicable to Health Insurance Program — *(Line 3 above)*	3.7 %	14.4 %
8. Total cost applicable to Health Insurance Program *(Line 6 multiplied by line 7)* transfer to Sch. A-1, Line 10	$ 2,910	$ 11,324

Per EXHIBIT IV

(1) 360 visits @ $6.00 = $2,160

(2) 1,050 visits @ $6.00 = $6,300
350 visits for 3 hrs.
@ $2.00 per hour = 2,100
$8,400

COST ADJUSTMENTS FOR NON-COVERED HOME HEALTH SERVICES

(To be used with Schedule A-9)

SCHEDULE A-10

(Include also costs of services for which no charge is made)

	DESCRIPTION	AMOUNT
1.	Clinics, classes, etc.	$ 6,152
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.	Total Cost of Non-Covered Services *(Sum of Lines 1 through 9) (Enter on Line 5, Schedule A-9)*	$ 6,152

FORM SSA-1728 (7-67)

Rev. 4

EXHIBIT VIII

PROVIDER NO. 00-7000

COST ADJUSTMENTS FOR NON-COVERED HOSPITAL-BASED HOME HEALTH SERVICES

SCHEDULE A-3

PERIOD: YE 6/30/67

(Include also costs of services for which no charge is made)

DESCRIPTION	AMOUNT	
1. Clinics, classes, etc.	$ 6,152	
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10. Total Cost of Non-Covered Services *(Sum of Lines 1 through 9)* *(Enter on Line 5–Schedule A-1)*	6,152	$

HOME HEALTH SERVICES DIRECT EXPENSE ANALYSIS

SCHEDULE A-4

ITEMIZE DIRECT HOME HEALTH COSTS	AMOUNT	
1. SALARY COSTS	$	
(a) Administrative Staff	15,105	
(b) Consultants		
(c) Professional Nurses	39,000	
(d) Interns/Residents		
(e) Other *(Specify)* Physical Therapist	6,950	
(f) Home Health Aides	7,645	
(g)		
(h)		
(i)		$ 68,700
2. CONTRACT SERVICES		
(a) Visiting Nurse Association	$	
(b) Equipment Rentals	200	
(c) Other *(Specify)*		
(d) Building rental for clinics, classes, etc.	600	
(e)		
(f)		800
3. MEDICAL SUPPLIES AND EXPENSES *(Specify)*	$ 634	
(a)		
(b)		634
4. TRANSPORTATION COSTS *(Specify)*		
(a) Operating costs and insurance	$ 3,856	
(b) Travel allowances and public transportation	974	4,830
5. OTHER DIRECT EXPENSES *(Specify)*	$	
(a) Legal and accounting	100	
(b)		
(c)		
(d)		
(e)		100
6. Total Direct Home Health Expenses *(Sum of lines 1(a) through 5(e))* *(Line 6 should agree with Home Health Cost Center – Column 1, Form 1562, Worksheet B)*		$ 75,064

U. S. GOVERNMENT PRINTING OFFICE : 1968 O - 325-263

Ref HD7102 U4A3 15, no. 11

EALTH INSURANCE FOR THE AGED

PROVIDER REIMBURSEMENT MANUAL

REVISION

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
HIM-15

October 1969 NO. 11

New Material	Page No.	Replaced Pages
Table of Contents, Chapter 11	11-1 (1 p.)	11-1 (1 p.)
Chapter 11	11-3 (1 p.)	11-3 (1 p.)

Chapter 11, Allowance in Lieu of Specific Recognition of Other Costs, has been revised to reflect the provisions of Regulation 405.428 and explains that such allowance is not includable as an element of reasonable cost of provider services for months after June 30, 1969. In addition, the method of transitional adjustment required for purposes of final settlement of provider reporting periods for months before July 1969 is described in section 1102 c .

Thomas M. Tierney, Director
Bureau of Health Insurance

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Chapter 11

ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

	Section	Page
Principle	1100	11-3
Application of Allowance	1102	11-3
Cost Basis for Computing Allowance	1104	11-3

1100. PRINCIPLE
An allowance in lieu of specific recognition of other costs in providing and improving services is includable as an element of the reasonable cost of services of providers for months before July 1, 1969.

1102. APPLICATION OF ALLOWANCE
The allowance in lieu of specific recognition of other costs is determined by applying a flat percentage rate to the total amount of otherwise allowable costs (see §1104) determined under the principles of reimbursement, and should be applied as follows:

a. Cost Reporting Period Ending Before July 1, 1969.--The full allowance should be included in total allowable costs for the reporting period.

b. Cost Reporting Period Beginning After June 30, 1969.--The allowance should not be included as an element of total allowable costs for reporting periods after this date.

c. Cost Reporting Period Beginning Before July 1, 1969, and Ending After June 30, 1969 .--For this transitional period, a pro rata share of the total allowance computable for that reporting year is to be included in total allowable costs for those months in the reporting period which precedes July 1, 1969. The full allowance should be calculated and the sum so obtained shall be apportioned to that part of the period before July 1, 1969, by applying to that sum a fraction consisting of a numerator which is the number of months before July 1969, and a denominator which is the number of months in the cost reporting period. (Where a cost reporting period begins on a day other than the first day of the month or ends on a day other than the last day of the month, the computation is made in terms of days instead of months, i.e., the days in the reporting period before July 1969 shall be included in the numerator and the total days in the reporting period shall be included in the denominator.) The following rates are applicable in determining the amount of the allowance:

Non-profit provider	2%
Proprietary provider	1 1/2%

1104. COST BASIS FOR COMPUTING ALLOWANCE
The base amount of costs to which the rate is applied in determining the allowance under this principle is allowable costs as determined under the principles of reimbursement, excluding:

a. interest expense (see chapter 2)

b. the allowance under this principle, and

c. for proprietary providers, the return allowed on equity capital (see chapter 12).

Qual. HD 7102 .74 A3 15 no.12

HEALTH INSURANCE FOR THE AGED

PROVIDER REIMBURSEMENT MANUAL

REVISION

U.S. DEPARTMENT OF
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SOCIAL SECURITY ADMINISTRATION
HIM-15

DECEMBER 1969 NO. 12

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
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New Material	Page No.	Replaced Pages
Sec. 2126.2	21-16.1 (1 p.)	---

This transmittal revises § 2126.2 and extends through calendar year 1970 the policy that, where utilization review in an ECF covers only Medicare patients, compensation to physicians for services on a utilization review committee is allocated 100 percent to Medicare. It also clarifies that an apportionment is necessary where the committee's activities extend to other health care programs.

Thomas M. Tierney, Director
Bureau of Health Insurance

Action Notes: Delete all of § 2126.2 on page 21-16.

In § 2126.3, second paragraph, fifth line, add "1970."

2126.2 Utilization Review in Extended Care Facilities.--

a. Physicians' Services.--Payments made to physicians for their services on utilization review committees are allowable as costs, whether or not the utilization review covers the entire patient population of the extended care facility. Allowable costs are limited to the payment of a reasonable compensation to the physician.

Where utilization review covers only Medicare beneficiaries, compensation to physicians for their utilization review services performed in calendar years through and including 1970 is reimbursable 100 percent by the Medicare program.

If the scope of an ECF utilization review committee's activity does not include all patients but does extend to services furnished to patients under other health care programs--such as Medicaid--the ECF's (or committee's) records of activities and compensation paid to the physician members of such a committee should be sufficient to serve as the basis for a proper apportionment of these costs between programs. Where, in the judgment of the intermediary, these costs are apportioned correctly, Medicare should reimburse 100 percent of the portion allocated to the Medicare program. However, where the utilization review committee activities apply to more than Medicare covered services but a valid allocation between Medicare and the other programs is not supported by documentation, all utilization review costs should be apportioned among all users of the extended care facility.

b. Costs Other Than for Physicians' Services.--Administrative costs related to utilization review and costs of professional personnel other than physicians are allowable costs and are apportioned among all of the users of the ECF, whether or not utilization review covers the entire patient population.

Generally, these costs are allocated as a part of the administrative costs of the facility. However, where utilization review is performed by a committee external to the facility (§ 2126.3) and the ECF is a distinct part of a larger facility, the entire cost of this committee may be charged directly to the distinct part ECF. The costs identified as other than for physicians' services will then be apportioned among the users of the distinct part ECF.

Cover HD 7102 .U4A3 15 no.13

HEALTH INSURANCE FOR THE AGED

PROVIDER REIMBURSEMENT MANUAL

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JANUARY 1970 NO. 13

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
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New Material	Page No.	Replaced Pages
Provider Reimbursement Manual Index	i-xi (11 pp.)	---

This transmittal furnishes an index for the Provider Reimbursement Manual. The index should be filed at the end of the manual.

Thomas M. Tierney, Director
Bureau of Health Insurance

References are to Section Numbers

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Orig. HD7102 .U4 A3 15 no.14

PROVIDER REIMBURSEMENT MANUAL

REVISION

HEALTH INSURANCE FOR THE AGED

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
HIM-15

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
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New Material	Page No.	Replaced Pages
Table of Contents, Chapter 21	21-1 -21-2 (2 pp.)	21-1-21-2 (2 pp.)
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Section 2136ff., Advertising Costs, and Section 2138ff., Membership Costs, provide specific instructions on the treatment of provider-incurred advertising and membership costs. The instructions do not reflect new policy but expand on the existing program position on these costs. Regulation § 405.451 specifies that all payments to providers must be based on the reasonable cost of such services covered under title XVIII and related to the care of beneficiaries. This yardstick of measuring reasonable cost must necessarily apply to the allowability of advertising and membership costs.

Section 2140ff., Deferred Compensation, establishes the requirements which deferred compensation plans for the benefit of participating employees of providers must meet to qualify for reimbursement under Medicare. This material does not cover pension plans; separate instructions regarding pension plans are being prepared.

To allow providers time to meet the conditions for deferred compensation plans, the requirements are effective June 1, 1970. If a provider has any liability to a deferred compensation plan fund for prior cost reporting periods, such liability must be paid by June 1, 1970.

Thomas M. Tierney, Director
Bureau of Health Insurance

Chapter 21

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2136. ADVERTISING COSTS--GENERAL

The treatment of advertising costs, i.e., their allowability, depends on whether they are reasonable, appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries by providers of services. To be reimbursable, such costs must be common and accepted occurrences in the field of the provider's activity. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions.

2136.1 Allowable Advertising Costs.--Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category (see § 2136.2).

Costs of advertising for the purpose of recruiting medical and paramedical personnel for the provider's salaried staff are allowable. Costs incurred in advertising for administrative or clerical personnel are allowable if the personnel would be involved in patient care activities or the development and maintenance of the facility.

Costs of advertising for procurement of scarce items or services related to patient care, and for sale or disposition of surplus or scrap material may be treated as adjustments of the purchase or selling price.

Advertising costs incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset (see Chapter I, § 104.10).

Advertising costs incurred in connection with bond issues are allowable when the proceeds of the bonds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities. The advertising costs would be included in "Bond Expenses" and would be prorated over the life of the bonds.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

2136.2 Unallowable Advertising Costs.--Fund-raising costs, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

While costs of advertising for the purpose of recruitment of physicians as members of the provider's salaried staff are allowable, (see § 2136.1), costs of advertising of a general nature designed to invite physicians to utilize the provider's facilities in their capacity as independent practitioners are not allowable. Professional contact costs, as discussed below, are allowable if reasonable.

Advertising costs incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not includable in allowable costs.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Social Security Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services cannot properly be related to the care of patients.

On the other hand, reasonable costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations and financial position, or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and fuction of the facility as a provider of covered health care in the community. The cost of listing the facility in a telephone directory or in a directory of similar facilities in a given area is allowable.

2138. MEMBERSHIP COSTS--GENERAL

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs.

Some of those organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicare purposes the allowability of costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (1) professional, technical or business related; (2) civic; and (3) social, fraternal, and other.

2138.1 Professional, Technical, or Business Related Organizations.--The Medicare program classifies organizations in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations, while not restricted to providers, are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities.

Costs of memberships in such organizations are allowable for purposes of program reimbursement. These costs include initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals. Also included are costs related to meetings and conferences, such as meals, transportation, registration fees and other costs incidental to those functions, when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operation of the facility.

2138.2 Civic Organizations.--These organizations function for the purpose of implementing civic objectives. Reasonable costs of initiation fees, dues, special assessments, and subscriptions to periodicals of civic organizations are allowable. Also allowable are those reasonable costs related to meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions when the primary purpose of such meetings and conferences is the promotion of civic objectives.

2138.3 Social, Fraternal, and Other Organizations.--Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of beneficiaries. Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

2138.4 Reasonableness of Provider's Participation in Approved Membership Activities.--The program will look to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.

2140. DEFERRED COMPENSATION

2140.1 Definition.--Deferred compensation is direct remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. Deferred compensation plans may include profit sharing, stock bonus, and annuity plans. The cost of deferred compensation plans are allowable if the requirements outlined below are met. These requirements are effective June 1, 1970.

2140.2 Formal Plan.--The deferred compensation plan must be formal and communicated to all eligible employees. A formal plan is covered by a written agreement between the provider and the participating employees. It is a permanent plan which (a) prescribes the method for calculating both the provider's and the employee's contributions to the fund established under the plan, (b) provides for the protection of the plan's assets, (c) designates the requirements for vested benefits, and (d) provides the basis for the computation of the amount of benefits to be paid.

A. Contributions.--The deferred compensation plan must be established by the provider and contributions may be made by the provider and/or the employees. For example, an employee may agree to a division of his $13,000 salary so that $12,000 is received as immediate renumeration and $1,000 is set aside as an employee contribution to the deferred compensation plan. The provider also contributes $2,000 to the deferred compensation plan on behalf of the employee. Of course, a provider's annual cost for an employee's total compensation ($15,000 in the foregoing example) must be reasonable in relation to the services rendered by the employee. Likewise, contributions by a provider to a deferred compensation plan on behalf of an employee-owner of a provider are considered to be a part of the owner's compensation and are subject to the test of reasonableness. (See § 902.3.)

B. Plan's Assets.--

1. Investment and Administration.--Contributions to the deferred compensation plan may be used to purchase an insured plan with a commercial insurance company or to establish a trust fund administered by a trustee for the sole benefit of the participating employees. The trustee may be either a member of the provider's organization or a third-party trustee. Where a trust fund is created for a deferred compensation plan, trustee(s) should be appointed by the equivalent of an executive board or committee of the provider organization to protect the fund's assets and its distribution to the beneficiaries under the plan.

2. Transactions.--A deferred compensation plan established primarily for the financial benefit or gain of the provider will not be allowed under the Medicare program. All financial matters of the plan must be transacted under conditions comparable to arm's length transactions. The trust fund cannot obtain securities and other property at more than adequate consideration nor sell its assets at less than adequate consideration.

3. Earnings.--The plan must specify that the interest, capital gains and losses, and dividends earned from the investment of the fund's assets will be added to or deducted from the corpus of the deferred compensation fund. Since income earned on loans to the general fund by the deferred compensation fund is not considered income to the provider, it, therefore, is not required to be offset against the allowable interest expense. However, before such loans are made, the reasons for such loans should be carefully reviewed to assure that the deferred compensation plan is not serving any purpose other than that for which it was intended (i.e., for the exclusive benefit of participating employees).

C. Vested Benefits.--The deferred compensation plan must specify the conditions for the benefits to become vested; e.g., after a predetermined number of years of employment, or after a specific age is attained, or some combination of the two. The schedule of benefits which accrue to an employee or his survivors upon the employee's retirement, termination of services because of disability, death, or other reasons, must be incorporated into the plan.

D. Benefits to be Paid.--Contributions by the employee to the deferred compensation fund are nonforfeitable. If an employee terminates his participation in the deferred compensation plan before his rights are vested, the applicable nonvested provider contributions and earnings of the plan cannot be applied to increase the benefits of the surviving participants, but must be applied to reduce the provider's contributions. However, the plan may prescribe that an amount in excess of the employee contributions (e.g., interest) be refunded to the employee who terminates his participation in the plan before his rights are vested. If an employee terminates his participation in the plan after his rights are vested, then the final payment to the employee will be made in accordance with the terms of the plan. If circumstances require the employer to terminate the plan, the rights of the participating employees become fully vested, and accordingly, the assets accumulated by the plan must be distributed exclusively to the participating employees or their beneficiaries.

2140.3 Requirements to Fund Plan.--A provider must meet its liability to the fund established for the deferred compensation plan within 75 days after the close of the provider's cost reporting period. The allowable cost of the deferred compensation plan must be reduced by any amount by which the liability is not so discharged. In addition, payment in excess of the liability to the plan cannot be included in allowable costs.

If a provider has any liability to a deferred compensation plan for prior cost reporting periods, such liability must be paid by June 1, 1970, or 75 days from the close of the provider's cost reporting period, whichever is later.

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AUDIT PROGRAM FOR HOSPITALS UNDER THE HEALTH INSURANCE FOR THE AGED ACT

TITLE XVIII

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM16 (10–67)

AUDIT PROGRAM
FOR HOSPITALS

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AUDIT PROGRAM FOR HOSPITALS
UNDER THE HEALTH INSURANCE FOR THE AGED ACT

PART I—INTRODUCTION

A. Authority

This program has been prepared by the Social Security Administration in collaboration with the Audit Agency of the Department of Health, Education, and Welfare under the provisions of Sections 1816, 1842, 1861(v)(1), and 1871 of the Health Insurance for the Aged Act, Social Security Amendments of 1965, Public Law 89-97. The Act authorizes the Secretary of Health, Education, and Welfare to prescribe such regulations as may be necessary to carry out the administration of the insurance programs under Title XVIII.

B. Responsibility

The Secretary has the responsibility to establish regulations to be followed in the examination of financial and statistical records of providers being paid reasonable cost for services rendered to beneficiaries of the program. The examination would be made to ascertain that reasonable cost was determined in accordance with those regulations established by the Secretary.

C. Purpose

This program and accompanying "Provider (Hospital) Audit Check List" are designed to provide the auditors with an outline of minimum procedures to be considered during an examination of the accounting and statistical records of hospitals that are providers of services under the Health Insurance for the Aged Act. This program is also designed to prevent omission of important phases of the audit.

D. Objectives

The following objectives for the audit of hospitals are established to assist the Secretary to discharge his responsibilities under the Health Insurance for the Aged Act: to aid in formulation of policy; and to provide verified financial and statistical information as a basis for decisions and reports to the Congress of the United States:

1. To ascertain that the hospital is conforming to the Health Insurance for the Aged Act (Public Law 89-97) with respect to the payment regulations thereunder.
2. To review, analyze, test, and verify the hospital's financial and statistical books and records and to determine that only proper items of cost applicable to hospital services have been included in reimbursable cost. Where the above words are used in this program, the following generally accepted meanings are intended:
 a. Review—to study critically
 b. Analyze—break into significant component parts in order to determine the nature of something
 c. Test—to examine representative items or samples for the purpose of arriving at a conclusion as to the group from which the sample is selected
 d. Verify—to establish accuracy
3. To verify on a selective basis that expenses attributable to the health insurance program have been reasonably determined.
4. To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation are sufficient to properly develop valid and accurate statistical information.
5. To make maximum utilization of hospital audits performed by others, where available, insofar as they reasonably further the audit objectives of the Bureau of Health Insurance.

E. Scope of the Audit

In the absence of any specific instructions by the intermediary, the scope of the audit should be determined by the auditor subsequent to his work at the auditor's office (and/or intermediary's office) (Part II-A) and tour of the hospital plant.

To assist in determining the scope of the audit, an annual general review should be made of the system of internal control in each hospital.

Another factor for determining the scope of the audit is a review of current and/or previous audit reports which may have been prepared by the organization's staff, independent public accountant, or others. Such items as the period covered, area examined,

findings, and recommendations made in these reports, may enable the auditor to ascertain areas that have inadequate procedures and controls as well as those that have been omitted or not sufficiently examined.

This audit program is not intended to place a maximum limitation on the scope or extent of the audit, nor is it intended as a substitute for the exercise of judgment. It is intended to permit the auditor to examine those areas that he considers necessary for the successful conclusion of the audit program. Additional or more intensive examinations may be warranted whenever indicated by local circumstances.

The audit may be made by means of complete or partial analyses, tests, or sampling methods.

F. Non-Availability of Records

During the examination of the hospital's records, the auditor should limit himself to only those records that are essential to the full accomplishment of the audit. Whenever he requests the hospital to provide records for review and such requests are denied, he should make the circumstances the subject of a special note in his work papers and report; and the intermediary should be consulted at once to determine whether the examination should be continued.

G. Disclosure of Contents of Audit Program and Results of Audit

The auditor is not to discuss or disclose the contents of the audit program or otherwise provide information with respect to specific audit approaches to anyone except authorized representatives of the intermediary and the Secretary. The scope of the audit and the overall audit objectives and approaches should be discussed, however, with appropriate officials of the provider during the initial conference at the start of the audit. The results of audit are to be discussed with officials of the provider and intermediary during the audit and at the exit conference as appropriate under the circumstances—(Part III-D). Audit working papers, programs, and reports pertaining to each provider audit will be retained by the auditor for at least three years after final payment for services under the contract for services.

H. Reporting

Upon completion of the examination, the auditor will prepare an audit report or a separate report. The audit report or the separate report should contain any suggestions for improvements in the provider's accounting and internal control systems which the auditor deems necessary or desirable for the development of reliable cost data under the principles of reimbursement. In this connection, the inclusion of suggestions for improvement is especially important where the related audit report contains a qualified opinion or a disclaimer of opinion. Examples of some situations where a qualified opinion or disclaimer of opinion might be appropriate are shown in Exhibit "A" attached.

The form of certification to be included in the audit report should, depending on the situation, conform to the forms shown in Exhibit "A" attached hereto. At a later date, more detailed instructions dealing with the format and contents of audit reports will be issued by the Secretary.

AUDIT PROGRAM

PART II—GENERAL INSTRUCTIONS

A. Work at the Auditor's and/or Intermediary's Offices

1. Before contacting the hospital to be audited, the auditor should become familiar with Public Law 89-97, the regulations thereunder and the approved principles of reimbursement. In addition, the auditor should discuss with the intermediary the possibility and need for reviewing the hospital file maintained at the intermediary's office to become familiar with contents of pertinent documents that might be relative to the hospital audit. Such documents could include:

 a. Contracts, if any

 b. Financial Statements

 c. Audit Reports

 d. Statistical Reports

 e. Correspondence

 f. Other pertinent information

2. The auditor should compare this cost statement with the prior one and note on worksheets any material differences of expenses shown on the two statements for subsequent investigation.

3. With respect to any records, books, documents, independent public accountant audit reports, and auditor's adjustments, etc., which the intermediary's auditor might wish the hospital to produce, he should make provision that they will be available at the site to be audited *prior to* his departure from his office.

4. The auditor should ascertain whether an audit has been completed by an independent public accountant covering the period of the cost report and if so whether all necessary adjustments were made to the books and records.

B. Pre-Audit Work at the Hospital

1. During preliminary discussions with officials of the hospital under audit, the auditor should request that certain documents be placed at his disposal during the audit, including:

 a. Accounting books and records that are used in keeping account of the financial operations of the hospital.

 b. Statistical reports pertaining to the information furnished on the cost report.

 c. Audit reports of the organization's own staff or others.

 (1) Special request should be made to obtain a copy of the latest audit, made by independent public accountant and made a part of audit work papers.

 (2) Request a copy of the latest audit report prepared by any other third party payer's auditors.

 d. Any or all types of reports that were prepared by the hospital in connection with the health insurance program or any other Federal program (where cost reimbursement is involved). (Note: These should be reviewed to determine that the revenue and expenses compare generally with those included in the cost reporting forms for the health insurance program. Any conflict in handling of similar items, relative to reimbursement, between Federal programs should be brought to the attention of the intermediary and the Social Security Administration.)

 e. Schedule of hospital room and board daily charges and schedule of charges for ancillary services for all patients at beginning and ending of reporting period. (Note: Schedule changes during the period should be reviewed to determine that such changes for room and board daily charges are according to accommodations for all patients and charges for ancillary services are the same for all patients using such services.)

 f. All work papers supporting allocations, calculations, etc., on the cost statement.

 g. A trial balance of all funds, for all accounts included in the general ledger (to be retained in audit work papers).

 h. All minutes of the hospital and any of its committees.

2. The auditor should confer with the management of the hospital about unusual variations found in comparing the current hospital cost statement with that of the preceding year. Replies should be noted on the worksheet recording the reason for such changes.

3. If it is the auditor's first visit to the hospital, possibly he should request a tour of the plant which will give him an opportunity to observe new equipment, additions, renovations, etc. If he had audited the facility prior to the current engagement, he should revisit those areas previously surveyed if it is indicated after discussion with the hospital officials that another visual survey is in order.

4. Upon completion of the preliminary survey, the auditor should review the material that was requested prior to the tour and determine that all records requested are available. The auditor should exercise the usual control of all records and documents made available exclusively for for his use during the audit.

C. Adjustments

1. During the examination of the records, etc., the auditor should notify the responsible representative of the hospital of adjustments to be made as soon as possible. This will give the hospital officials the opportunity to take such corrective or remedial action as may be necessary prior to the conclusion of the audit and also to expedite the "exit conference" as described in Part III-D.

 a. Any adjustment required as a result of the audit should be noted on the "Adjustment Report" prepared by the auditor and made part of the work papers. The report should show the date, description of the adjustment, the dollar amount, and the hospital official contacted. It should also indicate whether the hospital official agreed with the change to the cost report.

 b. If an adjustment(s) is required which will materially affect the cost report, the auditor should advise the intermediary so that consideration can be given to any possible effect on the current interim payment. If the hospital does not agree with the proposed change, the intermediary should be advised so that he can discuss it with the hospital.

D. Audit Work at the Hospital

1. If the auditor is unable to obtain a trial balance under B-1-g above, prepare a trial balance of all funds, for all accounts included in the hospital's general ledger.

 a. Compare expense accounts on the trial balance with those on the cost report.

 b. Reconcile (and evaluate differences between) total expenses on the trial balance with the total expenses on the cost report.

 c. Reconcile (and evaluate differences between) total expenses on the trial balance and cost report with the hospital's annual independent audit report. (Review last year's reconciling items for comparability.)

2. Examination of expense accounts.

 a. In connection with the examination of expense accounts, the following accounts should be given special emphasis and where necessary, analyzed on a test basis or in total to determine improper capital items and unallowable expenses:

 (1) Miscellaneous expense account or Miscellaneous category (if any) included under other expense accounts. (Materiality should be recognized when making judgment to analyze.)

 (2) Maintenance and repairs

 (3) Operation of plant

 (4) Professional fees (other than medical)

 (5) Administration and general

 b. Limited tests should be made of the following accounts to ascertain that charges thereto are reasonable and do not include capital items excludable from reimbursable cost:

 (1) Laboratory supplies and expenses

 (2) X-ray supplies and expenses

 (3) Pharmacy supplies and expenses

 (4) Dietary supplies and expenses

 (5) Operating room supplies and expenses

 c. Support salary expense (by departments) for the period by appropriate tests.

d. Analyze interest expense for the period under review. Determine unallowable amount, if any, based on principle 1-2, *Interest Expense* (Reg. Sec. 405.419).*

e. Review bad debts, if any, charged to health insurance program and determine that collection effort was made. Such bad debts should be restricted to the deductibles and coinsurance amounts not collected, as reflected in principle 1-3, *Bad Debts, Charity, and Courtesy Allowances* (Reg. Sec. 405.420).

f. Review and analyze, where necessary, on a test basis the fixed asset accounts. The auditor should satisfy himself as to the proper classification. Support major additions for the period and test the classification. Attention is directed to the cost basis to be used for the purchase of a facility as an on-going operation after July 1, 1966, as explained in principle 1-1A, *Allowance for Depreciation Based on Asset Costs* (Reg. Sec. 405.415). In the initial audit, some background and historical information should be included in work papers regarding buildings and valuations, etc. The hospital's capitalization policy should be reviewed and noted in work papers.

g. Review and test the computation of depreciation for the period, including review of the reasonableness of rates. (Reference may be made to the rates shown by American Hospital Association and Internal Revenue Service.) Determine that claimed depreciation expense meets the requirements of principle 1-1, *Depreciation* (Reg. Secs. 405.415-405.418).

h. Review and analyze, where necessary, any new expense account (new service, etc.) to determine the appropriateness and its applicability to reimbursable hospital expenses.

i. Rent expense should be analyzed for the year and supported by reference to leases, correspondence, etc. The auditor should determine that expense paid or incurred between parties, as discussed in principle 1-10, *Cost to Related Organizations* (Reg. Sec. 405.427), are in accordance with a proper application of that principle. Lease agreements (with option to buy) should be reviewed and if substantial differences between normal depreciation and lease arrangements exist these should be noted and commented upon. Sale and lease-back arrangements should be reviewed and adjusted where necessary in accordance with manual instructions.

j. The expenses attributable to the following accounts (and similar items) are not to be included in patient costs; a careful review should be made to determine that such items have been correctly treated in accordance with health insurance program principles and regulations. If the expenses (including applicable indirect costs) cannot be segregated and identified then the income received should be used as a recovery:

(1) Telephone service (pay stations excluded)

(2) Radio and television service

(3) Laundry service

(4) Linen service

(5) Employee and guest meals

(6) Sale of drugs to other than patients (including going-home drugs)

(7) Sale of medical and surgical supplies to other than patients

(8) Sale of medical records and abstracts

(9) Sale of scrap, waste, etc.

(10) Rental of quarters to employees and others

(11) Rental of hospital space

(12) Payments received from specialists

(13) Trade, quantity, time, and other discounts on purchases

(14) Rebates and refunds of expenses

(15) Fundraising expenses

(16) Private duty nurses

(17) Nursing school (tuition, fees, sale of textbooks, etc.)

* This reference is to the stated principle of the *Principles of Reimbursement For Provider Costs*. Similar references will be made throughout the *Audit Program* and the accompanying *Check List*.

(18) Grants, gifts, and income designated by the donor for specific operating expenses

(19) Recovery of insured loss

(20) Amount applicable to Part B for hospital-based physicians

(21) Research (except for those covered by principle 1-5, *Research Costs* (Reg. Sec. 405.422)

(22) Personal expenses of owner(s), etc.

(23) Expenses of operating gift shops, snack bars, etc.

(24) Commissions—vending machines

(25) Any other expenses not applicable to patient care

k. Inquiry should be made of the hospital's officials as to the extent, if any, of business conducted with related organizations. In addition, the auditor should be alert to note any amounts in the expense accounts analyzed that pertain to transactions with related organizations. The allowability of these expenses should be determined in accordance with principle 1-10, *Cost to Related Organizations* (Reg. Sec. 405.427).

3. Examination of income accounts

a. If the hospital has grants, these should be reviewed to determine if the principal and/or income affects the health insurance program reimbursable cost in any way.

b. Review all other income accounts on the trial balance for possible recoveries of expenses. Analyze where necessary to determine that all recoveries were included as such in the cost report (i.e., "Miscellaneous Income" if applicable).

c. Where applicable, test segregation of total charges to patients, departmentally, between health insurance program patients and total other patients and compare with percentages used in cost statement for application of RCCAC (ratio of charges to charges applied to cost).

d. Tests should be made to determine that the schedule of hospital charges applied to health insurance program patients and all other patients are consistent and comparable. Test verify with a copy of rates shown in the schedules obtained in Part II-B-1, step e. Inquiry should be made as to whether the hospital has any special charging arrangements (other than the regular schedule) with special groups such as group practice prepayment plans which would effect the RCCAC application.

e. Prepare schedule of selected admissions to the hospital, ascertain respective dates of discharge, and substantiate charges for room and board and all credits or allowances for periods of occupancy. This test should include health insurance program patients and other patients.

f. Trace from the records of each ancillary service department to the patients' accounts, both health insurance program and other patients, selected charges for services and test prices charged. Medical record charts may be used for this purpose.

4. Additional audit activity

a. Review any other accounts on the trial balance where the content is not known and which may affect the cost statement, such as capital fund account, retained earnings, surplus, etc. In some instances the year end audit report may show this information.

b. Review and analyze, if necessary, any other balance sheet account which may affect the final determination of reimbursable costs; e.g., "inventories," "prepaid expenses," and "accrued expenses."

c. Determine the reason for any unusual and material fluctuation in expense or income account and balance sheet accounts for this period as compared with the prior period. Make some analyses if necessary. Explain the difference in the work papers. This refers to those accounts whose fluctuations were not examined during the cost statement review.

d. Determine that any recommendations or adjustments included in the prior cost audit that affected this period were handled correctly.

e. Review and determine (test basis or otherwise) the accuracy of the computation of the settlement, included in the cost reports, be-

tween the provider and the intermediary. This will include verifying the "charges" portion of the settlement calculation with the hospital's books and records.

5. Verification of statistical information

 a. Test verify inpatient statistics and outpatient statistics shown on page 1 of the cost report (Form SSA-1563):

 (1) Inpatient days—Test verify the daily listings on the monthly summaries to the daily census sheets and test some footing totals of the daily census sheets. Test add the monthly summaries and compare with the amount shown on the cost report. Reference should be made to a limited number of medical histories and traced through to the daily census listings during period. Conversely, some tests should be made from daily census listings to medical histories.

 (2) Admissions and discharges—Test verify the monthly summary total of admissions and discharges with the basic record in the admissions office and/or the business office of the hospital. Add (on test basis) the monthly summaries and compare with the cost report figures. By limited tests determine that segregation of the above statistics between health insurance program patients and other patients are reasonably correct. Any material fluctuations between the periods should be questioned.

 b. Review and test the accuracy of the statistics for the general service departments and the special service departments (where such statistics are used as the basis of cost allocations) to the basic records of original entry.

E. Profit-Oriented Entities

1. The foregoing audit program has been designed primarily for the examination of the books and records of eleemosynary and other hospitals not organized or operated for profit. The following additional audit procedures should be considered in the examination of proprietary institutions:

 a. Auditors should review insurance expense and other expense accounts for possible elimination of personal and unallowable items. Special attention should be given to principles 1-9, *Compensation of Owners* (Reg. Sec. 405.426), and 1-10, *Cost to Related Organizations* (Reg. Sec. 405.427). If in the opinion of the auditor payments to owners appear excessive this should be reported to the intermediary for decision.

 b. Paid or accrued income taxes are not to be considered as an item of reimbursable cost and should be eliminated.

F. Miscellaneous

1. For hospitals including in allowable costs any amounts for voluntary services by individuals, including services of members of religious orders, obtain a schedule showing salary and other allowances by occupation, and the department to which the annual amount is charged. Review this schedule to determine that amounts allowed do not exceed those amounts paid to others for similar services. Determine that maintenance costs for religious personnel are not included in the allowance. Retain the schedule in the work papers. The requirements of principle 1-7, *Value of Services of Nonpaid Workers* (Reg. Sec. 405.424), should be applied in these cases.

2. The amounts and bases of allocation of expenses to and from affiliated nursing homes, universities, etc., (which are connected with the hospital operations) should be carefully reviewed.

3. Review contracts with and costs applicable to hospital-based physicians and other professional people on the payroll to determine reimbursable amounts under Public Law 89-97 and the regulations thereunder.

4. Expenses relative to approved educational actvities as defined in principle 1-4, *Cost of Educational Activities* (Reg. Sec. 405.421), should be reviewed and the amount subject to reimbursement under Public Law 89-97 determined.

5. Grants, gifts, and income from endowments should be tested to detemine applicability of principle 1-6, *Grants, Gifts, and Income From Endowments* (Reg. Sec. 405.423), and any necessary adjustments made to the cost schedules.

6. Determine that the amount of current financing, if any, under the health insurance program shown on the hospital records agrees with amount shown by the intermediary.

7. Review income and expense accounts in other funds (i.e., endowment, plant, and temporary) to determine if any amounts might affect the cost report. Analyze where necessary.

8. Determine that the cost computed under principle 1-11, *Allowance in Lieu of Specific Recognition of Other Costs* (Reg. Sec. 405.428), is correct.

9. Determine that the cost computed under principle 1-12, *Return on Equity Capital of Proprietary Providers* (Reg. Sec. 405.429), is correct.

AUDIT PROGRAM

PART III—CONCLUSION

A. Review of Working Papers and Schedules

At the conclusion of the examination, the auditor should possess all of the data in his work papers necessary to support and explain the list of changes included on the "Adjustment Report."

Before leaving the hospital, the auditor should review the work papers to assure that all data, information, schedules, and necessary notes are included to adequately support the audit.

The "Provider (Hospital) Audit Check List" should be reviewed to determine that all functions listed thereon have been completed and initialed. This list should be made a part of the work papers.

B. Return of Basic Documents

The auditor should be certain at the conclusion of the audit that he has returned all of the hospital's files, books, and documents in the same condition as they were presented to him.

C. Audit Results

All of the proposed adjustments to the cost report must be included on the "Adjustment Report" which should be prepared in triplicate. The auditor should have the hospital calculate the final net change and prepare the revised cost report upon which the auditor will render his opinion. The auditor will make a complete mathematical verification of the revised cost report and supporting data.

D. Exit Conference

An exit conference should be arranged by the auditor with the administrator and/or financial executive of the hospital. All changes listed on the "Adjustment Report" should be discussed. The hospital representative should be requested to sign two copies of the "Adjustment Report" indicating agreement to the changes in the cost report. The third copy of the "Adjustment Report" should be given to the hospital. One signed copy of the report should be retained by the auditor in his work papers and one copy should be sent to the intermediary with a corrected copy of the cost report. If the hospital executives and the auditor cannot agree to all the proposed changes then the intermediary should be requested to participate in the conference to resolve the disagreement.

E. Summary of Notes on Audit

A "Summary of Notes on Audit" should be included in the work papers listing any unusual facts concerning this audit and any relevant information that may assist the auditor performing the next audit.

F. Audit Guides

During the conduct of the examination, the auditor should be constantly aware of and guided by the provisions of the *General Principles of Reimbursement* (principles 2-1 through 2-4 (Reg. Secs. 405.451-405.454) which interpret the requirements for reimbursement included in Public Law 89-97. The legal limitations of reimbursement which are embodied in the "reasonable cost" concept and the requirements that only those costs attributable to beneficiaries of the program be reimbursed, serve as appropriate guidelines in determining the extent of allowable reimbursement.

EXHIBIT A

SUGGESTED FORMS OF CERTIFICATION

Provider No. _____

CERTIFICATION BY PUBLIC ACCOUNTANT

(Use only when auditor for intermediary is other than auditor for provider)

We have examined items 4, 9a, 10, 11d, 11e, 12 and 14 of page 1, and pages 2 and 3 of the accompanying Hospital Statement of Reimbursable Cost (Form SSA-1563) for _____ _____ for the period ended _____. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the audit program for hospitals issued by the Department of Health, Education, and Welfare, as we considered applicable and necessary in the circumstances.

We have not examined the financial statements of _____ _____ as of _____ and for the year then ended and, accordingly, we do not express an opinion on them. Such statements were examined by other independent accountants who have reported on them under date of _____.

In our opinion, the aforementioned items and pages of Form SSA-1563 for the period ended _____ _____ present fairly in all material respects the information shown therein, in conformity with the Agreement pursuant to Section 1866 of the Social Security Act of 1965 between _____ _____ and the Social Security Administration, dated _____ _____ and the published accounting principles and regulations issued by the Secretary of Health, Education, and Welfare applicable to Form SSA-1563, applied as described in the notes to the Hospital Statement of Reimbursable Cost.

SIGNATURE

DATE

EXHIBIT A

Provider No. _____

CERTIFICATION BY PUBLIC ACCOUNTANT

(Use only when no audit of financial statements of provider)

We have examined items 4, 9a, 10, 11d, 11e, 12 and 14 of page 1, and pages 2 and 3 of the accompanying Hospital Statement of Reimbursable Cost (Form SSA-1563) for _____ _____ for the period ended _____. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the audit program for hospitals issued by the Department of Health, Education, and Welfare, as we considered applicable and necessary in the circumstances.

We have not examined the financial statements of _____ as of _____ and for the year then ended and accordingly, we do not express an opinion on them. Nor were such financial statements examined by other independent accountants.

In our opinion, the aforementioned items and pages of Form SSA-1563 for the period ended _____ _____ present fairly in all material respects the information shown therein, in conformity with the Agreement pursuant to Section 1866 of the Social Security Act of 1965 between _____ _____ and the Social Security Administration, dated _____ and the published accounting principles and regulations issued by the Secretary of Health, Education, and Welfare applicable to Form SSA-1563, applied as described in the notes to the Hospital Statement of Reimbursable Cost.

SIGNATURE

DATE

EXHIBIT A

Provider No. _____

CERTIFICATION BY PUBLIC ACCOUNTANT

(Use only when auditor for intermediary is auditor for provider)

We have examined the financial statements of the _____ _____ as of _____ and for the year then ended, and have reported thereon under date of _____.

Supplementing our examination of the financial statements, we have also examined Items 4, 9a, 10, 11d, 11e, 12 and 14 of page 1, and pages 2 and 3 of the accompanying Hospital Statement of Reimbursable Cost (Form SSA-1563) for the period ended _____. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the audit program for hospitals issued by the Department of Health, Education and Welfare, as we considered applicable and necessary in the circumstances.

In our opinion, the aforementioned items and pages of Form SSA-1563 for the period ended _____ _____ present fairly in all material respects the information shown therein, in conformity with the Agreement pursuant to Section 1866 of the Social Security Act of 1965 between _____ _____ and the Social Security Administration, dated _____ _____ and the published accounting principles and regulations issued by the Secretary of Health, Education, and Welfare applicable to Form SSA-1563, applied as described in the notes to the Hospital Statement of Reimbursable Cost.

SIGNATURE

DATE

EXHIBIT A

Provider No. _____

CERTIFICATION BY PUBLIC ACCOUNTANT

(Examples of Opinions—Qualifications and Disclaimers)

Situations will be encountered in which the independent accountant will be unable to give an unqualified opinion on the claim for reimbursable cost. Instead he may have to give a qualified opinion or disclaimer of opinion. Some of the circumstances which may arise are:

1. Exception as to the inclusion of one or more items of cost.
2. Exception as to one or more bases of allocation of costs.
 a) As between departments.
 b) As between Health Insurance Program patients and other patients.
3. Exception as to the validity of one or more statistics.
4. Some element or elements of the accounting or statistical records cannot be audited satisfactorily
5. The timing of the examination is such that it is impossible to determine inventories, receivables or payables at the beginning and/or end of the accounting period. This problem may be particularly troublesome where the accounting records are maintained on the cash basis or there has been a change in method during the period.
6. The claim has not been prepared in accordance with the accounting requirements of the Department of Health, Education, and Welfare.

In situations such as 1, 2, 3 and 6, above, it may be possible to determine the effect on the amount of the claim. If so, the facts, including the amount of the adjustment to the claim, should be recited in a paragraph preceding the opinion paragraph, and the opinion will be modified as follows:

"In our opinion, the aforementioned items and pages of Form SSA-1563 for the period ended _____, after adjustment as described in the preceding paragraph, . . ."

Where the amount of the adjustment cannot be determined, it will be necessary to evaluate the range of discrepancy which may result. At the lower end of the scale of materiality, it may be possible to give a qualified opinion as follows:

"In our opinion, except for the required adjustment with regard to (the matter discussed in the preceding paragraph) . . ."

If the materiality of the adjustment is of greater magnitude, the following language may be appropriate:

"Because the (matter discussed in the preceding paragraph enters materially into the determination of reimbursable cost, we do not express an opinion on the fairness of the claim."

The independent accountant should then recite the items or segments of the claim on which he can give an opinion.

Situations such as 4 and 5 above will, depending upon the degree of materiality, require an exception or disclaimer. The language cited above can be used with appropriate modification.

There may be certain situations, such as where questions relate to the interpretation of the accounting requirements of the Department of Health, Education, and Welfare, in which the qualifying phrase "subject to" is appropriate. An example follows:

"In our opinion, subject to the final determination of (the matter discussed in the preceding paragraph) . . ."

However, where the amount concerned is sufficiently material, a qualified opinion is inappropriate and a disclaimer of opinion will be required (see Statements on Auditing Procedure No. 33, AICPA, pages 72-74).

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AUDIT PROGRAM FOR HOME HEALTH AGENCIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

TITLE XVIII

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM17 (1-68)

AUDIT PROGRAM
FOR HOME HEALTH AGENCIES

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AUDIT PROGRAM FOR HOME HEALTH AGENCIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

PART I—INTRODUCTION

A. Authority

This audit program has been prepared by the Department of Health, Education, and Welfare under the provisions of Sections 1816, 1842, 1861(v)(1), and 1871 of the Health Insurance for the Aged Act, Social Security Amendments of 1965, Public Law 89–97. The Act authorizes the Secretary of Health, Education, and Welfare to prescribe such regulations as may be necessary to carry out the administration of the insurance programs under Title XVIII.

B. Responsibility

The Secretary has the responsibility to establish regulations to be followed in the examination of financial and statistical records of providers being paid reasonable cost for services rendered to beneficiaries of the program. The Secretary has delegated to the Social Security Administration (SSA) the responsibility for policy formulation and the general management and operational aspects of the program including the prescribing of principles of reimbursement and related policies for use by providers in determining the reasonable cost of services furnished to beneficiaries. To facilitate the making of payments to providers for services furnished beneficiaries, the SSA has entered into agreements with private organizations to act as intermediaries for the purpose, among others, of determining the amount of reimbursement to be made to providers. Reimbursement is made directly by the intermediaries during the year on an estimated basis and final settlement is based on audited statements of provider's costs submitted on an annual basis.

C. Purpose

The examination is to be made in accordance with generally accepted auditing standards and must include, as a minimum, the auditing procedures prescribed by this audit program. The program is designed to provide the auditors with an outline of the minimum procedures to be considered during an examination of the accounting and statistical records of home health agencies that are providers of services under the Health Insurance for the Aged Act. This program is also designed to aid in preventing the omission of important phases of the audit.

D. Objectives

The overall objectives of the audit of home health agencies are to provide the intermediary with verified financial information as a basis for making a final determination of allowable costs; to assist the Secretary to discharge his responsibilities under the Health Insurance for the Aged Act; to aid in formulation of policy; and to provide verified financial and statistical information as a basis for decisions and reports to the Congress of the United States. More specifically, the objectives are:

1. To ascertain that the home health agency is conforming to the intent of the Health Insurance for the Aged Act (Public Law 89–97) with respect to the payment regulations thereunder.

2. To review, analyze, test, and verify the home health agency's financial and statistical books and records and to determine that only proper items of cost applicable to services furnished beneficiaries have been included in reimbursable cost. Where the above words are used in this program, the following generally accepted meanings are intended:

 a. Review—to study critically

 b. Analyze—to break into significant component parts in order to determine the nature of something

 c. Test—to examine representative items or samples for the purpose of arriving at a conclusion as to the group from which the sample is selected

 d. Verify—to establish accuracy

3. To verify on a selective basis that expenses attributable to the health insurance program have been accurately determined and are reasonable.

4. To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation are sufficient to properly develop valid and accurate statistical information.

E. Scope of Audit

The audit must be sufficiently comprehensive in scope to permit the expression in the audit report of an opinion as to whether, in all material respects, the required schedules present fairly the reimbursable costs of the home health agency in conformity with the Principles of Reimbursement for Provider Costs issued by the Secretary. The auditor should make maximum utilization of home health agency audits made by others, where available, insofar as such audits reasonably further the audit objectives of the program. As in any other examination, the auditor reporting on information contained in the cost reimbursement schedule should obtain sufficient evidential matter to form a reasonable basis for his opinion.

The effectiveness of internal controls, the nature of the providers' records, and the extent of audit work performed by the providers' auditor or other third-party auditors should be considered by the intermediary-appointed auditor in determining the scope of audit work to be performed. In selecting the procedures to be applied and the extent of testing to be done, the auditor should rely to the extent possible on the work of other auditors in the same manner that highly effective internal control procedures are utilized.

The audit program is not intended to place a maximum limitation on the scope or extent of the audit, nor is it intended as a substitute for the exercise of judgment by the auditor. The auditor should examine those areas that he considers necessary for the successful conclusion of the audit. Additional or more intensive examinations may be warranted whenever indicated by local circumstances.

The audit may be made by means of complete or partial analyses, tests, or sampling methods.

F. Reporting

An audit report must be prepared and submitted to the intermediary upon completion of the examination of each home health agency. The auditor should comment on the agency's accounting and internal control systems insofar as they pertain to or affect the development of cost data under the prescribed principles of reimbursement. In addition, where the audit report contains a qualified opinion or a disclaimer of opinion, the comments should disclose the deficiencies which prevented the expression of an unqualified opinion and should offer suggestions for improvement. The auditor's certificate should, depending on the circumstances, conform to the forms included in Exhibit A attached.

The auditor may elect to issue a separate report containing the auditor's comments, findings, and recommendations relating to matters that do not affect the rendition of an opinion on the agency's statement of reimbursable costs. When a separate report is prepared, it should be submitted to the intermediary together with the audit report on the statement of reimbursable costs, if possible, and in any event within 30 days after submission of the audit report. Where the auditor finds or observes that the home health agency is not complying with directives issued by the intermediary or the SSA to a degree affecting the economical or effective operation of the program, these instances of noncompliance are to be disclosed and discussed in the comments.

Notwithstanding any provisions to the contrary, if the intermediary instructs the auditor to perform so limited an audit that the audit firm is not able to express and overall opinion as to the fairness of reasonable costs, then the auditor's report to the intermediary shall be limited to a summary of the audit work actually performed and a listing of any matters noted in such examination which would reflect on the fairness of reasonable costs.

G. Non-Availability of Records

During the examination of the home health agency's records, the auditor should limit him-

self to only those records that are essential to the full accomplishment of the audit. Whenever he requests the home health agency to provide records for review and such requests are denied, he should make the circumstances the subject of a special note in his workpapers and report, and the intermediary should be consulted at once to determine whether the examination should be continued.

H. Disclosure of Contents of Audit Program and Results of Audit

The auditor is not to discuss or disclose the contents of the audit program or otherwise provide information with respect to specific audit approaches to anyone except authorized representatives of the intermediary and the Secretary. The scope of the audit and *overall* audit objectives and approaches should be discussed, however, with appropriate officials of the home health agency during the initial conference at the start of the audit. The results of the audit are to be discussed with officials of the provider and intermediary during the audit and at the exit conference as appropriate under the circumstances (Part III-D). Audit working papers, programs, and reports, including permanent files and reviews of internal controls, pertaining to each provider audit, will be retained by the auditor for at least three years after final payment for services under the contract for services and will be made available to representatives of the Secretary and the intermediary, at all reasonable times, for review and obtaining any necessary information.

I. Audit Guides

During the course of the examination, the auditor should look to the General Principles of Reimbursement 2–1 through 2–4 (Reg. Secs. 405.451–405.454)* which interpret the reimbursement provisions of Public Law 89–97. The legal limitations of reimbursement which are embodied in the "reasonable cost" concept and the requirements that only those costs attributable to beneficiaries of the program be reimbursed, serve as guidelines in determining the extent of allowable reimbursement. In addition to Public Law 89–97, the Health Insurance for the Aged Act, the following SSA publications will provide the auditor a general knowledge of the Health Insurance for the Aged program as it relates to home health agencies.

Home Health Agency Manual (HIM-11)
Principles of Reimbursement for Provider Costs (HIM-5)
Conditions of Participation for Home Health Agencies (HIM-2)

The auditor shall refer questions of interpretation of the Social Security Act, as amended, or Principles of Reimbursement for Provider Costs to the intermediary. The auditor may accept the written reply of the intermediary to the questions as conclusive.

* This reference is to the stated principle of the Principles of Reimbursement for Provider Costs (HIM–5, Revised 1–67). Similar references will be made throughout the Audit Program.

PART II—GENERAL INSTRUCTIONS

A. Work at the Auditor's and/or Intermediary's Offices

1. Before contacting the home health agency to be audited, the auditor should become familiar with Public Law 89–97, the regulations thereunder, and the approved principles of reimbursement. In addition, the auditor should discuss with the intermediary the possibility and need for reviewing the home health agency file maintained at the intermediary's office to become familiar with the contents of pertinent documents that might be related to the home health agency audit. Such documents could include:

 a. Contracts, if any, especially contracted services pertaining to medicare beneficiaries.

 b. Financial statements including interim reimbursement payments.

 c. Audit reports.

 d. Statistical reports including time studies and public health reports.

 e. Correspondence.

 f. Cost reports submitted by the agency to other third-party payors.

 g. Other pertinent information.

2. The auditor should compare the current statement of reimbursable cost (SSA form 1728 or 1729) with the prior one and note on worksheets for subsequent investigation any material differences of expenses shown on the two statements.

3. Prior to his arrival at the audit site, the intermediary's auditor should make arrangements with the home health agency to make available when he arrives such records, books, documents, time studies, independent public accountant reports, auditor's adjustments, etc., which he deems necessary to the proper conduct of the audit.

4. The auditor should ascertain whether an audit has been completed by an independent public accountant covering the period of the statement of reimbursable cost and if so whether all necessary adjustments were made to the books and records.

5. The auditor should arrange to meet with the provider's auditor for the purpose of determining the extent of audit work done. He should discuss with the provider's auditor the scope of their work and their conclusions and refer to their audit program and working papers in order that he may select the procedures to be applied and the extent of testing to be done to form a reasonable basis for his opinion on information contained in the statement of reimbursable cost.

B. Adjustments

1. During the examination of the records, etc., the auditor should promptly notify the responsible representative of the home health agency of adjustments to be made. This will give the home health agency officials the opportunity to take such corrective or remedial action as may be necessary prior to the conclusion of the audit and should expedite the "exit conference" described in Part III-D.

 a. Any adjustment required as a result of the audit should be noted on the "Adjustment Report" prepared by the auditor and made part of the workpapers. The report should show the date, description of the adjustment, the dollar amount, and the home health agency official contacted. It should also indicate whether the home health agency official agreed with the related change to the statement of reimbursable cost.

 b. If an adjustment is required which will materially affect the statement of reimbursable cost, the auditor should advise the intermediary so that consideration can be given to any possible effect on the

current interim payment. If the responsible representative of the home health agency does not agree with the proposed change, the intermediary should be promptly advised so that he can discuss it with the home health agency's representative.

C. Audit Work at the Home Health Agency

1. During preliminary discussion with officials of the home health agency, the auditor should request that certain documents be placed at his disposal during the audit, including:

 a. Accounting books and records that are used in keeping account of the financial operations of the home health agency.

 b. Statistical reports pertaining to the information furnished on the statement of reimbursable cost.

 c. Cost studies prepared by the home health agency or by recognized organizations such as the National League for Nursing.

 d. Audit reports of the organization's own staff or others:

 (1) A copy of the latest audit report made by an independent public accountant should be requested for retention as a part of the audit workpapers.

 (2) A copy of the latest audit report prepared by any other third-party payer's auditors.

 e. Any or all types of reports that were prepared by the home health agency in connection with the health insurance program or any other Federal or State program (where cost reimbursement is involved—for example, National Institute of Health grants for their Research Project Program, General Research Support Program, and General Clinical Research Center Program). (Note: These should be reviewed to determine whether the revenues and expenses compare generally with those included in the cost reporting forms for the health insurance program. Any conflict in handling of similar items, relative to reimbursement, between Federal programs should be brought to the attention of the intermediary and the Social Security Administration.)

 f. Schedule of home health agency charges (fee schedule) for each type of visit made and also schedule of charges for other services such as rental of equipment for all patients at beginning and ending of reporting period. (Note: Schedule of charges during the period should be reviewed to determine that such charges, including any changes thereto, are applicable to all patients using such services.)

 g. All workpapers supporting allocations, calculations, etc., on the statement of reimbursable cost.

 h. A trial balance of all funds, for all accounts included in the general ledger (to be retained in audit workpapers).

 i. All minutes of the directorate of the home health agency and any of its committees.

2. The auditor should confer with the management of the home health agency about unusual variations found in comparing the current home health agency statement of reimbursable cost with that of the preceding year. Replies should be noted on the worksheet recording the reason for such changes.

3. If it is the auditor's first visit to the home health agency, he should request a tour of the agency which will give him an opportunity to observe new equipment, additions, renovations, etc. If he had audited the agency prior to the current engagement, he should revisit those areas previously surveyed if the need for such visit is indicated by his discussion with agency officials.

4. The auditor should review the material that was requested and determine whether all records requested are available. The auditor should exercise the usual physical control of all records and documents made available exclusively for his use during the audit.

5. If the auditor is unable to obtain a trial balance under C-1-h above, prepare a trial balance for all accounts included in the home health agency's general ledger.

 a. Compare expense accounts on the trial balance with those on the statement of reimbursable cost.

 b. Reconcile (and evaluate differences between) total expenses on the trial balance with the total expenses on the statement of reimbursable cost.

 c. Reconcile (and evaluate differences be tween) total expenses on the trial balance and statement of reimbursable cost with the home health agency's independent audit report. (Review last year's reconciling items for comparability.)

6. *Examination of expense accounts*

 a. In connection with the examination of expense accounts, the following accounts should be given special emphasis and where appropriate, analyzed to the extent necessary to reasonably assure that they do not include unallowable costs and items which should have been capitalized and depreciated.

 (1) Miscellaneous expense account or miscellaneous category (if any) included under other expense accounts. (Materiality should be recognized when making judgment to analyze.)

 (2) Maintenance and repairs

 (3) Professional fees (other than medical)

 (4) Administration and general

 (5) Services contracted for "under arrangements"

 (6) Mileage expense

 (7) Rental of durable equipment

 b. Limited tests should be made of the medical supply and equipment accounts to ascertain that charges thereto are reasonable and do not include capital items excludable from reimbursable costs. With regard to hospital-based home health agencies, limited tests should be made of the following accounts:

 (1) Laboratory supplies and expenses

 (2) X-ray supplies and expenses

 (3) Pharmacy supplies and expenses

 c. Support salary expense for the period of appropriate tests.

 d. Analyze interest expense for the period. Determine unallowable amount, if any, based on Principle 1–2, Interest Expense (Reg. Sec. 405.419).

 e. Review and analyze, where necessary, on a test basis, the fixed asset accounts. The auditor should satisfy himself as to the proper classification. Support major additions for the period and test the classification.
 In the initial audit, some background and historical information should be included in workpapers regarding fixed assets and valuations, etc. The home health agency's capitalization policy should be reviewed and noted in workpapers.

 f. Review and test the computation of depreciation for the period, including the reasonableness of rates. (Reference may be made to the rates shown by the American Hospital Association and Internal Revenue Service.) Determine whether claimed depreciation expense meets the requirements of Principle 1–1, Depreciation (Reg. Secs. 404.415–405.418).

 g. Review bad debts, if any, charged to the health insurance program and determine that collection effort was made. Such bad debts should be restricted to the deductibles and coinsurance amounts not collected, as reflected in Principle 1–3, Bad Debts, Charity, and Courtesy Allowances (Reg. Sec. 405. 420).

 h. Review and analyze, where necessary, any new expense account (new service, etc.) to determine the appropriateness and its applicability to reimbursable home health agency expenses.

 i. Review and determine (test basis or otherwise) the accuracy of non-visiting

expenses as stated on statement of reimbursable cost. If an allocation is made of such non-visiting expense on the basis of predetermined percentages, review and determine the reasonableness of the bases used for allocation. Expenditures not related to the program are to be eliminated.

j. Analyze rent expense by reference to leases, correspondence, etc. Imputed rent expense for facilities provided without charge is not an allowable cost.

k. The expenses attributable to the following accounts (and similar items) are not to be included in patient costs; a careful review should be made to determine that such items have been correctly treated in accordance with health insurance program principles and regulations. If the expenses (including applicable indirect costs) cannot be segregated and identified then the income received should be used as a recovery.

 (1) Expenses attributable to the sale of medical and surgical supplies to other than patients

 (2) Expenses attributable to the sale of medical records and abstracts

 (3) Personal expenses of owner(s), etc., (proprietary agency)

 (4) Fund-raising expenses

 (5) Any other expenses not applicable to patient care

l. Income related to the following accounts (and similar items) should be reflected in patient costs:

 (1) Trade, quantity, time, and other discounts on purchases

 (2) Rebates and refunds of expenses

 (3) Grants, gifts, and income designated by the donor for specific expenses

 (4) Commissions—vending machines

 (5) Recovery of insured losses

m. The auditor should be alert to note any amounts in the expense accounts that pertain to transactions with related organizations. The allowability of these expenses should be determined in accordance with Principle 1–10, Cost to Related Organizations (Reg. Sec. 405. 427).

7. *Examination of income accounts*

 a. If the home health agency has grants, particularly Public Health Service grants, these should be reviewed to determine if the principal and/or income affects the health insurance program reimbursable costs in any way.

 b. Review all other income accounts on the trial balance for possible recoveries of allowable expenses. Analyze where necessary to determine that all recoveries were included as such in the statement of reimbursable cost. ("Miscellaneous Income," if applicable).

 c. Where applicable, test the segregation of total charges to patients, departmentally, between health insurance program patients and total other patients and compare with percentages used in statement of reimbursable cost for application of RCC (ratio of charges to charges as applied to cost).

 d. Tests should be made to determine that the schedule of home health agency charges applied to health insurance program patients and all other patients are consistent and comparable.

 e. Prepare schedule of selected admissions for start of care, ascertain respective dates of visits made, and substantiate charges for visits and other services and all credits or allowances for periods of care. This test should include health insurance program patients and other patients.

 f. Trace from the records of other services provided (such as rental of equipment) to the patients' accounts, selected charges for services and test prices charged. Medical record charts may be used for this purpose.

8. *Additional audit activity*

a. Review any other accounts on the trial balance where the contents are not clear and which may affect the statement of reimbursable cost, such as capital fund account, etc. In some instances, the year-end audit report may show this information.

b. Review and analyze, if necessary, any other balance sheet accounts which may affect the final determination of reimbursable costs; e.g., "inventories," "prepaid expenses," and "accrued expenses."

c. Determine the reason for any unusual and material fluctuation in expense or income account and balance sheet accounts for this period as compared with the prior period. Analyze if necessary. Explain such difference in the workpapers. This refers to those accounts whose fluctuations were not examined during review of the statement of reimbursable cost.

d. Review and determine (test basis or otherwise) the accuracy of the computation of the settlements included in the statement of reimbursable cost. This will include verifying the "charges" portion of the settlement calculation with the home health agency's books and records.

9. *Verification of statistical information*

a. Test patient statistics submitted with the statement of reimbursable cost to the extent necessary to conclude that statistical information is reasonably valid and accurate.

(1) Number of visits—test the daily postings on the home health agency's summary records to the daily activity reports and test footings of the daily activity reports. Test the footings on the summary records and compare with the number shown on the statement of reimbursable cost. References should be made to a limited number of case files and traced through to the daily activity reports during the period. Conversely, tests should be made from daily activity reports to case files.

(2) Number of patients served—verify the summary records of admissions and discharges with the basic record in the business office of the home health agency. Test the footings on the summary records and compare with the statement of reimbursable cost figures.

(3) By limited tests, determine that proper segregation of the above statistics between health insurance program patients and other patients was made. Any material fluctuations between the periods should be questioned.

(4) Where any of the above statistics (medicare and non-medicare) are used on the statement of reimbursable cost form for allocations or determining the amount due, such totals should be compared with the home health agency's totals for the period.

b. Review and test the accuracy of the statistics for the number of visits made by the various disciplines, especially in those agencies being reimbursed at different rates by disciplines served.

c. Review and analyze selection of time study period to note if seasonal differences were considered; study was representative of activities of agency; a sufficient time period was included to obtain a fair sample; and if administrative controls were adequate to assure reasonably accurate results.

d. Test tabulation on time study sheets by tracing records to patient accounts and to summary sheet as well as personnel time.

e. Test for the proper elimination of "not home-not found," visits for medicare patients as well as non-covered services.

f. Test non-visiting time or percentage used in arriving at the non-visiting deduction.

10. *Miscellaneous*

a. For home health agencies that include in allowable costs amounts for voluntary services by individuals, including services of members of religious orders, obtain a schedule showing salary and other allowances by occupation and the service to which the annual amount is charged. The requirements of Principle 1–7, Value of Services of Nonpaid Workers (Reg. Sec. 405. 424), should be applied in these cases.

b. The amounts and bases of allocation of expenses to and from affiliated hospitals, nursing homes, universities, public health departments, etc. (which are connected with the home health agency's operations) should be carefully reviewed.

c. Review contracts with physicians and other professional people on the payroll to determine reimbursable amounts under Public Law 89–97 and the regulations thereunder. (Note: physicians' services must be rendered in the capacity of consultant or administrator.)

d. Expenses relative to approved educational activities as defined in principle 1–4, Cost of Educational Activities (Reg. Sec. 405.421) should be reviewed and the amount subject to reimbursement under Public Law 89–97 determined.

e. Determine that the amount of current financing, if any, under the health insurance program shown on the home health agency's records agrees with amount shown by the intermediary.

f. Review income and expense accounts of the agency (i.e., endowments, plant, and temporary) to determine if any amounts might affect the statement of reimbursable cost. Analyze where necessary.

g. Determine that the cost claimed under Principle 1–11, Allowance in Lieu of Specific Recognition of Other Costs (Reg. Sec. 405.428) is properly computed.

11. *Profit-Oriented Entities*

a. The foregoing audit program has been designed primarily for the examination of the books and records of eleemosynary and other home health agencies not organized or operated for profit. The following additional audit procedures should be considered in the examination of proprietary institutions.

(1) Insurance expense and other expense accounts should be reviewed for possible elimination of personal and unallowable items. Special attention should be given to Principles 1–9, Compensation of Owners (Reg. Sec. 405. 426). If, in the opinion of the auditor, payments to owners appear excessive, this should be reported to the intermediary for decision.

(2) Paid or accrued income taxes are not to be considered as an item of reimbursable cost and should be eliminated.

(3) Determine that the cost claimed under Principle 1–12, Return on Equity Capital of Proprietary Providers (Reg. Sec. 405.429) is properly computed.

AUDIT PROGRAM

PART III—CONCLUSION

A. Review of Workpapers and Schedules

At the conclusion of the examination, the auditor should possess all of the data in his workpapers necessary to support and explain the list of changes included on the "Adjustment Report."

Before leaving the home health agency, the auditor should review the workpapers to assure that all data, information, schedules, and necessary notes are included to adequately support the audit and the audit report.

The audit program, or a separate audit check list, should be included in the forepart of the audit working papers. Each audit step, or segment of related steps, should be initiated to indicate completion of the audit work required and cross-referenced to the supporting audit working papers. At the conclusion of the examination, the audit program, or audit checklist, should be reviewed to determine that all functions were performed or satisfactory explanation was recorded for those omitted.

B. Return of Basic Documents

The auditor should be certain at the conclusion of the audit that he has returned all of the home health agency's files, books, and documents in the same condition as they were presented to him.

C. Audit Results

All of the proposed adjustments to the statement of reimbursable cost must be included on the "Adjustment Report" which should be prepared in triplicate. The auditor should have the home health agency calculate the final net change and, depending on the number and dollar amount of the adjustments, a revised statement of reimbursable cost upon which the auditor will render his opinion. The auditor will make a complete mathematical verification of the revised statement of reimbursable cost and supporting data.

D. Exit Conference

An exit conference should be arranged by the auditor with the administrator and/or financial executive of the home health agency. All changes listed on the "Adjustment Report" should be discussed. The home health representative should be requested to sign two copies of the "Adjustment Report" indicating agreement to the changes in the statement of reimbursable cost. The third copy of the "Adjustment Report" should be given to the home health agency. One signed copy of the report should be retained by the auditor in his workpapers and one copy should be sent to the intermediary with a corrected copy of the statement of reimbursable cost. If the home health agency executives and the auditor cannot agree to all the proposed changes, then the intermediary should be requested to participate in the conference to resolve the disagreement.

E. Summary of Notes on Audit

A "Summary of Notes on Audit" should be included in the workpapers listing any unusual facts concerning this audit and any relevant information that may assist the author performing the next audit.

SUGGESTED FORMS OF CERTIFICATION

The form of opinion shown below is intended to be illustrative of the opinion that independent auditors should give where they have examined the home health agency's Statement of Reimbursable Costs. The illustrative forms of opinion, together with the accompanying comments, have been restated from a memorandum prepared by the Subcommittee on Compliance Reports of the Committee on Auditing Procedure of the American Institute of Certified Public Accountants relating to reports on examinations of hospital statements of reimbursable costs under medicare. Changes have been made only where appropriate to make the language applicable to the examination of home health agency costs.

Illustrative Form of Report

We have examined the information shown on page 2 of the Home Health Agency Statement of Reimbursable Cost (Form SSA–1728 or SSA–1729 as applicable) of the _____for the year ended _____. Our examination of this information was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the Audit Program for Home Health Agencies published by the Department of Health, Education, and Welfare, as we considered necessary in the circumstances.

In our opinion, page 2 of the accompanying Home Health Agency Statement of Reimbursable Cost presents fairly in all material respects the information shown therein, in conformity with the Principles of Reimbursement for Provider Costs published by the Secretary of Health, Education, and Welfare applied as described in the notes to the statement.

Signature

Date

The foregoing form of opinion is appropriate for use by the provider's auditor as well as by the intermediary-appointed auditors who may or may not have examined the provider's financial statements. In circumstances where the provider's unaudited financial statements, in complete or partial form, are included as part of the cost reimbursement schedule, such financial statements should be marked as "unaudited" and a middle paragraph should be added to the report expressing a disclaimer of opinion on the financial statements. Where the financial statements submitted have been examined by either (a) the auditor rendering the report on the Statement of Reimbursable cost or (b) the provider's auditor, a middle paragraph may be added as follows:

As to situation (a)

We have examined the financial statements of _____ for the year ended _____ and have rendered our report thereon under date of _____.

As to situation (b)

> We have not examined the financial statements of _____ for the year ended _____, and accordingly we do not express an opinion on them. Such statements were examined by other public accountants who have reported on them under date of _____.

Since inclusion of the middle paragraph is intended solely to furnish information about any examinations that may have been made of the financial statements included in the cost reimbursement schedule and not to indicate a sharing of responsibility, the opinion expressed as to the Statement of Reimbursable Cost should not be modified to refer to the middle paragraph.

Whatever the circumstances, as in the case of any engagement where an auditor expresses an opinion, the auditing work done should be sufficient to support the opinion.

Qualifications and Disclaimer of Opinion

Appropriate modification of the illustrative form will be required when the auditor finds it necessary to qualify his opinion or give a disclaimer of opinion.

There may be situations in which the auditor examining the costs claimed for reimbursement will not be able to formulate an opinion concerning such costs, or items included therein, either because restrictions were placed on the scope of his work by the Intermediary or because the condition of the records was such as to prevent him from performing the work necessary in the circumstances. In these situations, in reporting on the costs claimed, the auditor should be guided by the discussion of qualified opinion and disclaimers of opinion in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

There also may be situations where the auditor will conclude that information shown is not presented fairly. These situations may concern instances where, for example, the auditor concludes that the statements of cost do not present certain information in conformity with accounting requirements of the Department of Health, Education, and Welfare, or where cost allocations are made improperly or information is inaccurate. In those situations the auditor should be guided by the discussion of qualified opinions and adverse opinions in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

Special Examinations

Intermediaries may seek the advice and assistance of auditors with respect to various accounting and auditing matters associated with Medicare. This may include requests for special examinations, such as examinations of specific accounts of the home health agency's Statements of Reimbursable Cost examined by other auditors. The form of report to be submitted in such cases should be designed to fit the individual situation and should set forth clearly the scope of the work performed and the results. The auditor should be careful in reporting on such situations that he does not give the impression of having assumed more responsibility than his special examination warrants. Generally, the provisions of Chapter 13 of SAP No. 33 dealing with special reports apply to such situations. In some cases "negative assurance" type of reports may be appropriate, provided the conditions described in paragraph 21 of Chapter 10 of SAP No. 33 are met.

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HIM 18 (1-68)

AUDIT PROGRAM FOR EXTENDED CARE FACILITIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

TITLE XVIII

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

AUDIT PROGRAM
FOR EXTENDED CARE FACILITIES

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AUDIT PROGRAM FOR EXTENDED CARE FACILITIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

PART I—INTRODUCTION

A. *Authority*

This audit program has been prepared by the Department of Health, Education, and Welfare under the provisions of Sections 1816, 1842, 1861(v)(1), and 1871 of the Health Insurance for the Aged Act, Social Security Amendments of 1965, Public Law 89–97. The Act authorizes the Secretary of Health, Education, and Welfare to prescribe such regulations as may be necessary to carry out the administration of the insurance programs under Title XVIII.

B. *Responsibility*

The Secretary has the responsibility to establish regulations to be followed in the examination of financial and statistical records of providers being paid reasonable costs for services rendered to beneficiaries of the program. The Secretary has delegated to the Social Security Administration (SSA) the responsibility for policy formulation and the general management and operational aspects of the program including the prescribing of principles of reimbursement and related policies for use by providers in determining the reasonable cost of services furnished to beneficiaries. To facilitate the making of payments to providers for services furnished beneficiaries, the SSA has entered into agreements with private organizations to act as intermediaries for the purpose, among others, of determining the amount of reimbursement to be made to providers. Reimbursement is made directly by the intermediaries during the year on an estimated basis and final settlement is based on audited statements of providers' costs submitted on an annual basis.

C. *Purpose*

The examination is to be made in accordance with generally accepted auditing standards and must include, as a minimum, the auditing procedures prescribed by this audit program. The program is designed to provide the auditors with an outline of the minimum procedures to be considered during an examination of the accounting and statistical records of extended care facilities that are providers of services under the Health Insurance for the Aged Act. This program is also designed to aid in preventing the omission of important phases of the audit.

D. *Objectives*

The overall objectives of the audit of extended care facilities are to provide the intermediary with verified financial information as a basis for making a final determination of allowable costs; to assist the Secretary to discharge his responsibilities under the Health Insurance for the Aged Act; to aid in formulation of policy; and to provide verified financial and statistical information as a basis for decisions and reports to the Congress of the United States. More specifically, the objectives are:

1. To ascertain that the extended care facility is conforming to the intent of the Health Insurance for the Aged Act (Public Law 89–97) with respect to the payment regulations thereunder.

2. To review, analyze, test, and verify the extended care facility's financial and statistical books and records and to determine that only proper items of cost applicable to services furnished beneficiaries have been included in reimbursable cost. Where the above words are used in this program, the following generally accepted meanings are intended:

 a. Review—to study critically

 b. Analyze—to break into significant component parts in order to determine the nature of something

 c. Test—to examine representative items or samples for the purpose of arriving

at a conclusion as to the group from which the sample is selected

d. Verify—to establish accuracy

3. To verify on a selective basis that expenses attributable to the health insurance program have been accurately determined and are reasonable.

4. To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation are sufficient to properly develop valid and accurate statistical information.

E. Scope of Audit

The audit must be sufficiently comprehensive in scope to permit the expression in the audit report of an opinion as to whether, in all material respects, the reimbursement settlement schedule(s) of the ECF Statement of Reimbursable Cost present fairly the reimbursable costs of the extended care facility in conformity with the Principles of Reimbursement for Provider Costs issued by the Secretary. The auditor should make maximum utilization of extended care facility audits made by others, where available, insofar as such audits reasonably further the audit objectives of the program. As in any other examination, the auditor reporting on information contained in the reimbursement settlement schedule(s) should obtain sufficient evidential matter to form a reasonable basis for his opinion.

The effectiveness of internal controls, the nature of the providers' records, and the extent of audit work performed by the providers' auditor or other third-party auditors should be considered by the intermediary-appointed auditor in determining the scope of audit work to be performed. In selecting the procedures to be applied and the extent of testing to be done, the auditor should rely to the extent possible on the work of other auditors in the same manner that highly effective internal control procedures are utilized.

The audit program is not intended to place a maximum limitation on the scope or extent of the audit, nor is it intended as a substitute for the exercise of judgment by the auditor. The auditor should examine those areas that he considers necessary for the successful conclusion of the audit. Additional or more intensive examinations may be warranted whenever indicated by local circumstances.

The audit may be made by means of complete or partial analyses, tests, or sampling methods.

F. Reporting

An audit report must be prepared and submitted to the intermediary upon completion of the examination of each extended care facility. The auditor should comment on the facility's accounting and internal control systems insofar as they pertain to or affect the development of cost data under the prescribed principles of reimbursement. In addition, where the audit report contains a qualified opinion or a disclaimer of opinion, the comments should disclose the deficiencies which prevented the expression of an unqualified opinion and should offer suggestions for improvement. The auditor's certificate should, depending on the circumstances, conform to the forms included in Exhibit A, attached.

The auditor may elect to issue a separate report containing the auditor's comments, findings, and recommendations relating to matters that do not affect the rendition of an opinion on the reimbursement settlement schedule(s) of the facility's statement of reimbursable costs. When a separate report is prepared, it should be submitted to the intermediary together with the audit report on the statement of reimbursable costs, if possible, and in any event within 30 days after submission of the audit report. Where the auditor finds or observes that the extended care facility is not complying with directives issued by the intermediary or the SSA to a degree affecting the economical or effective operation of the program, these instances of noncompliance are to be disclosed and discussed in the comments.

Notwithstanding any provisions to the contrary, if the intermediary instructs the auditor to perform so limited an audit that the audit firm is not able to express an overall opinion as to the fairness of reasonable costs, then the auditor's report to the intermediary shall be limited to a summary of the audit work

actually performed and a listing of any matters noted in such examination which would reflect on the fairness of reasonable costs.

G. Non-Availability of Records

During the examination of the extended care facility's records, the auditor should limit himself to only those records that are essential to the full accomplishment of the audit. Whenever he requests the extended care facility to provide records for review and such requests are denied, he should make the circumstances the subject of a special note in his workpapers and report, and the intermediary should be consulted at once to determine whether the examination should be continued.

H. Disclosure of Contents of Audit Program and Results of Audit

The auditor is not to discuss or disclose the contents of the audit program or otherwise provide information with respects to specific audit approaches to anyone except authorized representatives of the intermediary and the Secretary. The scope of the audit and *overall* audit objectives and approaches should be discussed, however, with appropriate officials of the extended care facility during the initial conference at the start of the audit. The results of the audit are to be discussed with officials of the provider and intermediary during the audit and at the exit conference as appropriate under the circumstances (Part III–D). Audit working papers, programs, and reports, including permanent files and reviews of internal controls, pertaining to each provider audit will be retained by the auditor for at least three years after final payment for services under the contract for services and will be made available to representatives of the Secretary and the intermediary, at all reasonable times, for review and obtaining any necessary information.

I. Audit Guides

During the course of the examination, the auditor should look to the General Principles of Reimbursement 2-1 through 2-4 (Reg. Sec. 405.451–405.454)* which interpret the reimbursement provisions of Public Law 89–97. The legal limitations of reimbursement which are embodied in the "reasonable cost" concept and the requirements that only those costs attributable to beneficiaries of the program be reimbursed, serve as guidelines in determining the extent of allowable reimbursement. In addition to Public Law 89–97, the Health Insurance for the Aged Act, the following SSA publications will provide the auditor a general knowledge of the Health Insurance for the Aged program as it relates to extended care facilities:

Extended Care Facility Manual (HIM–12)
Principles of Reimbursement for Provider Costs (HIM–5)
Conditions of Participation for Extended Care Facilities (HIM–3)

The auditor shall refer questions of interpretations of the Social Security Act, as amended, or Principles of Reimbursement for Provider Costs to the intermediary. The auditor may accept the written reply of the intermediary to the questions as conclusive.

* This reference is to the stated principle of the Principles of Reimbursement for Provider Costs (HIM–5, Revised 1–67). Similar references will be made throughout the Audit Program.

AUDIT PROGRAM

PART II—GENERAL INSTRUCTIONS

A. Work at the Auditor's and/or Intermediary's Offices

1. Before contacting the extended care facility to be audited, the auditor should become familiar with Public Law 89–97, the regulations thereunder, and the approved principles of reimbursement. In addition, the auditor should discuss with the intermediary the possibility and need for reviewing the extended care facility file maintained at the intermediary's office to become familiar with the contents of pertinent documents that might be related to the extended care facility audit. Such documents could include:
 a. Contracts, if any, especially contracted services pertaining to medicare beneficiaries
 b. Financial statements including interim reimbursement payments
 c. Audit reports
 d. Statistical reports
 e. Correspondence
 f. Other pertinent information
2. The auditor should compare the current ECF statement of reimbursable cost with the prior one and note on worksheets for subsequent investigation any material differences of expenses shown on the two statements.
3. Prior to his arrival at the audit site, the intermediary's auditor should make arrangements with the extended care facility to make available when he arrives such records, books, documents, time studies, independent public accountant reports, auditor's adjustments, etc., which he deems necessary to the proper conduct of the audit.
4. The auditor should ascertain whether an audit has been completed by an independent public accountant covering the period of the statement of reimbursable cost and if so whether all necessary adjustments were made to the books and records.
5. The auditor should arrange to meet with the provider's auditor for the purpose of determining the extent of audit work done. He should discuss with the provider's auditor the scope of their work and their conclusions and refer to their audit program and working papers in order that he may select the procedures to be applied and the extent of testing to be done to form a reasonable basis for his opinion on information contained in the reimbursement settlement schedule(s) of the ECF statement of reimbursable cost.

B. Adjustments

1. During the examination of the records, etc., the auditor should promptly notify the responsible provider representative of proposed adjustments. This will give provider officials the opportunity to take such corrective or remedial action as may be necessary prior to the conclusion of the audit and also will expedite the "exit conference" as described in Part III–D.
 a. Any adjustment required as a result of the audit should be noted on an "Adjustment Report" prepared by the auditor and made part of the workpapers. The report should show the date, description of the adjustment, the dollar amount, and the extended care facility official contacted. It should also indicate whether the official agreed with the related change to the reimbursement settlement schedule(s).
 b. If adjustments are required which will materially affect the reimbursement settlement schedule(s) of the statement of reimbursable cost, the auditor should advise the intermediary so that consideration can be given to any possible effect on the current interim payment. If the responsible representative of the extended care facility does not agree with

the proposed changes, the intermediary should be advised so that he can discuss them with the provider's representative.

C. Audit Work at the Extended Care Facility

1. During preliminary discussion with officials of the extended care facility, the auditor should request that certain documents be placed at his disposal during the audit, including:
 a. Accounting books and records that are used in keeping account of the financial operations of the extended care facility.
 b. Statistical reports pertaining to the information furnished on the reimbursement settlement schedule(s) of the statement of reimbursable cost.
 c. Audit reports of the organization's own staff or others:
 (1) A copy of the latest audit report made by an independent public accountant should be requested for retention as a part of the audit workpapers.
 (2) A copy of the latest audit report prepared by any other third-party payer's auditors.
 d. Any or all types of reports that were prepared by the extended care facility in connection with the health insurance program or any other Federal program (where cost reimbursement is involved). For example, National Institute of Health grants for their Research Project Program, General Research Support Program, and General Clinical Research Center Program. (Note: These should be reviewed to determine whether the revenues and expenses compare generally with those included in the cost reporting forms for the health insurance program. Any conflict in handling of similar items, relative to reimbursement, between Federal programs should be brought to the attention of the intermediary and the Social Security Administration.)
 e. Schedules of charges for all patients at beginning and ending of reporting period. (Note: Schedule of charges during period should be reviewed to determine that such charges are effective for all patients and with no discrimination against any class of patients. To be acceptable, charges should be similar for all patients in the same type accommodations.)
 f. All workpapers supporting allocations, calculations, etc., on the reimbursement settlement schedule(s) of the statement of reimbursable cost.
 g. A trial balance of all funds, for all accounts included in the general ledger (to be retained in audit workpapers).
 h. All minutes of the directorate of the extended care facility and any of its committees.
2. The auditor should confer with the management of the extended care facility about unusual variations found in comparing the current statement of reimbursable cost with that of the preceding year. Replies should be noted on the worksheet recording the reasons for such changes.
3. If it is the auditor's first visit to the extended care facility, he should request a tour of the facility which will give him an opportunity to observe new equipment, additions, renovations, etc. If he had audited the facility prior to the current engagement, he should revisit those areas previously surveyed if the need for such visit is indicated by his discussion with provider officials.
4. Upon completion of preliminary work, the auditor should determine whether all records previously requested are available. The auditor should exercise the usual control of all records and documents made available exclusively for his use during the audit.
5. If the auditor is unable to obtain a trial balance under C–1–g above, prepare a trial balance of all funds, for all accounts included in the extended care facility's general ledger.
 a. Compare expense accounts on the trial

balance with those on the statement of reimbursable cost.

b. Reconcile (and evaluate differences between) total expenses on the trial balance with the total expenses on the statement of reimbursable cost.

c. Reconcile (and evaluate differences between) total expenses on the trial balance and statement of reimbursable cost with the audit report prepared by the extended care facility's outside auditors. (Review last year's reconciling items for comparability.)

6. Examination of expense accounts

a. If the auditor determines that any of the following audit procedures are not appropriate because of the limited amounts claimed in the provider's statement of reimbursable cost, or if he determines that the procedures have been adequately completed by the extended care facility's outside auditor and he is placing reliance thereon, he should include necessary explanations and/or cross-reference opposite the applicable procedures in the program. If applicable, the auditor should indicate in the workpapers the scope of the outside auditor's tests and should obtain copies of the outside auditor's workpapers where such documentation is needed to supplement or provide additional workpaper support.

During the examination of expenses, the auditor should note any transactions of material amount with provider-controlled or related organizations. The allowability of these expenses should be determined in accordance with Principle 1–10, Cost to Related Organizations (Reg. Sec. 405.427).

(1) The following accounts should be given special emphasis and, where necessary, analyzed to determine improper capital items and unallowable expenses (materiality should be considered when making judgment to analyze):

(a) Miscellaneous expense account or miscellaneous category (if any) included under other expense accounts

(b) Maintenance and repairs

(c) Operations of plant

(d) Professional fees (other than medical)

(e) Administration and general

(2) Limited tests should be made of the following accounts or expense categories to ascertain that charges thereto are reasonable and do not include capital items excludable from reimbursable cost:

(a) Nursing supplies and expenses

(b) Dietary supplies and expenses

(c) Pharmacy, laboratory, and x-ray supplies and expenses

(d) Supplies and expenses of special services

(3) Support salary expense (by departments) for the period by appropriate tests.

(4) Analyze interest expense for the period under review. Determine unallowable amount, if any, based on Principle 1–2, Interest Expense (Reg. Sec. 405.419).

(5) Review bad debts, if any, charged to the health insurance program and determine that collection effort was made. Such bad debts should be restricted to coinsurance amounts not collected, as reflected in Principle 1–3, Bad Debts, Charity, and Courtesy Allowances (Reg. Sec. 405.420).

(6) Review and analyze, where necessary, on a test basis, the fixed asset accounts. The auditor should satisfy himself as to the proper classification. Support major additions for the period and test the classification. Attention is directed to the cost basis to be used for the purchase of a facility as an on-going operation after July 1, 1966, as explained in Principle 1–1A, Allowance for Depreciation Based on Asset Costs

(Reg. Sec. 405.415). In the initial audit, some background and historical information should be included in workpapers regarding buildings, valuations, etc. The extended care facility's capitalization policy should be reviewed and noted in the workpapers.

(7) Review and test the computation of depreciation for the period, including the reasonableness of rates. Guidelines as to the reasonableness of rates may be obtained from publications of the American Hospital Association and the Internal Revenue Service. Determine that claimed depreciation expense meets the requirements of Principle 1–1, Depreciation (Reg. Secs. 405.415–405.418).

(8) Review and analyze, where necessary, any new expense account (new service, etc.) to determine the appropriateness and its applicability to reimbursable expenses.

(9) Rent expense should be analyzed and supported by reference to leases, correspondence, etc. The auditor should determine that expenses paid or incurred between related parties, as discussed in Principle 1–10, Cost to Related Organizations (Reg. Sec. 405.427), are in accordance with the proper application of that principle. Lease agreements (with option to buy) should be reviewed and, if substantial differences between normal depreciation and lease arrangements exist, these differences should be noted and commented upon. Sale and lease-back arrangements should be reviewed and adjusted where necessary in accordance with manual instructions.

(10) Costs and or expenses attributable to the following accounts (and similar items) are not to be included in patient costs; a review should be made to determine that such items have been correctly treated in accordance with health insurance program principles and regulations. In deciding upon the extent of the review, the materiality of the amounts involved should be considered. If the expenses (including applicable indirect costs) cannot be segregated and identified, then the income received should be used as a recovery:

(a) Telephone service (pay stations excluded)
(b) Radio and television service
(c) Laundry service for other than patients
(d) Linen service for other than patients
(e) Employee and guest meals
(f) Drugs and medical supplies sold to other than patients
(g) Private duty nurses
(h) Operation of gift shops and snack bars
(i) Personal expenses of owners
(j) Any other expenses not applicable to patient care

(11) Income related to the following accounts (and similar items) should be reflected in patient costs:

(a) Trade, quantity, time, and other discounts on purchases
(b) Rebates and refunds of expenses
(c) Grants, gifts, and income designated by the donor for specific expenses
(d) Commissions—vending machines
(e) Recovery of insured losses
(f) Rental of quarters to employees and others
(g) Sale of scrap, waste, etc.
(h) Payments received from specialists

7. Examination of income accounts
 a. If the extended care facility has grants, these should be reviewed to determine if the principal and/or income affects the health insurance program reimbursable cost in any way.

b. Review other income accounts on the trial balance for possible recoveries of expenses. Analyze where necessary to determine that recoveries were included as such in the statement of reimbursable cost. (i.e., "Miscellaneous Income" if applicable).

c. Where applicable, test segregation of total charges to patients, departmentally, between health insurance program patients and total other patients and compare with percentages used in statement of reimbursable cost for application of RCCAC (ratio of charges to charges applied to cost). If the Intermediary accumulates charges to health insurance program patients, this accumulation should be reconciled to amounts shown on the provider's statement of reimbursable cost.

d. Tests should be made to determine that the schedule of charges applied to health insurance program patients and all other patients are consistent and comparable. Compare on a test basis with a copy of rates shown in the schedules obtained in Part II–C–1, step e. Inquiry should be made as to whether the extended care facility has any special charging arrangements (other than the regular schedules) with special groups such as group practice prepayment plans which would affect the RCCAC application.

e. Prepare schedule of selected admissions to the extended care facility, ascertain respective dates of discharge, and substantiate charges and credits or allowances for periods of occupancy. This test should include health insurance program patients and other patients.

8. Additional audit activity

a. Review any other accounts on the trial balance where the content is not known and which may affect the statement of reimbursable cost, such as capital fund account, retained earnings, surplus, etc. In some instances the year end audit report may show this information.

b. Review and analyze, if necessary, any other balance sheet account which may affect the final determination of reimbursable costs; i.e., "inventories," "prepaid expenses," and "accrued expenses."

c. Determine the reason for any unusual and material fluctuation in expense or income accounts and balance sheet accounts for this period as compared with the prior period; analyze where necessary. Explain the differences in the workpapers. This refers to those accounts whose fluctuations were not examined during review of the statement of reimbursable cost.

d. Determine that any recommendations or adjustments included in the prior cost audit that affected this period were handled correctly.

e. Test the computation of the settlement, included in the reimbursement settlement schedule(s) of the statements of reimbursable cost between the provider and the Intermediary. This will include comparisons of the "charges" portion of the settlement calculation with the provider's books and records.

9. Test of statistical information

a. Review the extended care facility's method of gathering and reporting the statistical information shown on its statement of reimbursable cost. Limited tests of the statistical data should be made.

b. Include in the workpapers a brief description of the method followed by the provider and a conclusion as to the adequacy of the method and the reliability of the statistical information shown on the statement of reimbursable cost.

c. Where in-patient days are involved in the settlement computations, they might be tested by verifying the daily listings on the monthly summaries to the daily census sheets and test some footing totals of the daily census sheets. Test add the monthly summaries and compare with the amount shown on the statement of reimbursable cost. Reference should be made to a limited number of medical histories and traced through to the daily

census listings during the period. Conversely, some tests should be made from daily census listings to medical histories. By similar limited tests determine that accumulation of patient days for health insurance program patients is reasonably correct. If the Intermediary accumulates program patient days, this accumulation should be reconciled to that by the provider.

10. Miscellaneous

a. If the extended care facility includes amounts for voluntary services by individuals, including services of members of religious orders, obtain a schedule showing salary and other allowances by occupation, and the department to which the annual amount is charged. Review this schedule to determine that amounts allowed do not exceed those amounts paid to others for similar services. Determine that maintenance costs for religious personnel are not included in the allowance. Retain the schedule in the workpapers. The requirements of Principle 1–7, Value of Services of Nonpaid Workers (Reg. Sec. 405.424), should be applied in these cases.

b. The amounts and bases of allocation of expenses to and from affiliated hospitals, universities, nursing homes, public health departments, etc., (which are connected with the extended care facility's operations) should be carefully reviewed.

c. Review contracts with and costs applicable to facility-based physicians and other professional people on the payroll to determine reimbursable amounts under Public Law 89–97 and the regulations thereunder. (Note: physicians' services must be rendered in the capacity of consultant or administrator).

d. Expenses relative to approved educational activities as defined in Principle 1–4, Cost of Educational Activities (Reg. Sec. 405.421), should be reviewed and the amount subject to reimbursement under Public Law 89–97 determined.

e. Grants, gifts, and income from endowments should be tested to determine applicability of Principle 1–6, Grants, Gifts, and Income From Endowments (Reg. Sec. 405.423), and any necessary adjustments made to the cost schedules.

f. Determine that the amount of current financing, if any, under the health insurance program shown on the provider's records agrees with amount shown by the intermediary.

g. Review income and expense accounts in other funds (i.e., endowment, plant, and temporary) to determine if any amounts might affect the statement of reimbursable cost. Analyze where necessary.

h. Determine that the cost claimed under Principle 1–11, Allowance in Lieu of Specific Recognition of Other Costs (Reg. Sec. 405.428), is properly computed.

11. Profit Oriented Entities

a. If the extended care facility is a proprietary institution, the following additional audit procedures should be considered:

(1) Review insurance expense and other expense accounts to determine whether personal and other unallowable items are included. Special attention should be given to Principles 1–9, Compensation of Owners (Reg. Sec. 405.426), and 1–10, Cost to Related Organizations (Reg. Sec. 405.427). If, in the auditor's opinion, payments to owners appear excessive, the information should be reported to the Intermediary.

(2) Paid or accrued income taxes are not allowable items of reimbursable costs.

(3) Determine that the cost claimed under Principle 1–12, Return on Equity Capital of Proprietary Providers (Reg. Sec. 405.429), is properly computed.

PART III—CONCLUSION

A. Review of Work Papers and Schedules

At the conclusion of the examination, the auditor should possess all of the data in his workpapers necessary to support and explain the list of changes included on the "Adjustment Report."

Before leaving the extended care facility, the auditor should review the workpapers to assure that all data, information, schedules, and necessary notes are included to adequately support the audit and the audit report.

The audit program, or a separate audit check list, should be included in the forepart of the audit working papers. Each audit step, or segment of related steps, should be initialed to indicate completion of the audit work required and cross referenced to the supporting audit working papers. At the conclusion of the examination, the audit program, or audit check list, should be reviewed to determine that all functions were performed or satisfactory explanation was recorded for those omitted.

B. Return of Basic Documents

The auditor should be certain that at the conclusion of the audit he has returned all of the extended care facility's files, books, and documents in the same condition as they were presented to him.

C. Audit Results

All of the proposed adjustments to the reimbursement settlement schedule(s) of the statement of reimbursable cost must be included on the "Adjustment Report" which should be prepared in triplicate. The auditor should have the extended care facility calculate the final net change and prepare the revised reimbursement settlement schedule(s) of the statement of reimbursable cost upon which the auditor will render his opinion. The auditor will make a complete mathematical verification of the revised reimbursement settlement schedule(s) and supporting data.

D. Exit Conference

An exit conference should be arranged by the auditor with the administrator and/or financial executive of the extended care facility. All changes listed on the "Adjustment Report" should be discussed. The extended care facility's representative should be requested to sign two copies of the "Adjustment Report" indicating agreement to the changes in the cost report. The third copy of the "Adjustment Report" should be given to the extended care facility. One signed copy of the report should be retained by the auditor in his workpapers and one copy should be sent to the intermediary with a corrected copy of the statement of reimbusable cost. If the extended care facility's executives and the auditor cannot agree to all the proposed changes, then the intermediary should be requested to participate in the conference to resolve the disagreement.

E. Summary of Notes on Audit

A "Summary of Notes on Audit" should be included in the workpapers listing any unusual facts concerning this audit and any relevant information that may assist the auditor performing the next audit.

SUGGESTED FORMS OF CERTIFICATION

The form of opinion shown below is intended to be illustrative of the opinion that independent auditors should give where they have examined the extended care facility's Statement of Reimbursable Costs. The illustrative forms of opinion, together with the accompanying comments, have been restated from a memorandum prepared by the Subcommittee on Compliance Reports of the Committee on Auditing Procedure of the American Institute of Certified Public Accountants relating to reports on examinations of hospital statements of reimbursable costs under medicare. Changes have been made only where appropriate to make the language applicable to the examination of extended care facility costs.

Illustrative Form of Report

We have examined the information shown on the reimbursement settlement schedule(s) of the Extended Care Facility Statement of Reimbursable Cost of the _____ for the year ended _____. Our examination of this information was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the Audit Program for Extended Care Facilities published by the Department of Health, Education, and Welfare, as we considered necessary in the circumstances.

In our opinion, the reimbursement settlement schedule(s) of the accompanying Extended Care Facility Statement of Reimbursable Cost present fairly in all material respects the information shown therein, in conformity with the Principles of Reimbursement for Provider Costs published by the Secretary of Health, Education, and Welfare applied as described in the notes to the statement.

Signature

Date

The foregoing form of opinion is appropriate for use by the provider's auditor as well as by the intermediary-appointed auditors who may or may not have examined the provider's financial statements. In circumstances where the provider's unaudited financial statements, in complete or partial form, are included as part of the statement of reimbursable cost, such financial statements should be marked as "unaudited" and a middle paragraph should be added to the report expressing a disclaimer of opinion on the financial statements. Where the financial statements submitted have been examined by either (a) the auditor rendering the report on the reimbursement settlement schedule(s) of the Statement of Reimbursable Cost or (b) the provider's auditor a middle paragraph may be added as follows:

As to situation (a)

We have examined the financial statements of _____ for the year ended _____ and have rendered our report thereon under date of _____.

As to situation (b)

> We have not examined the financial statements of _____ for the year ended _____, and accordingly we do not express an opinion on them. Such statements were examined by other public accountants who have reported on them under date of _____.

Since inclusion of the middle paragraph is intended solely to furnish information about any examinations that may have been made of the financial statements included in the statement of reimbursable cost and not to indicate a sharing of responsibility, the opinion expressed as to the reimbursement settlement schedule(s) of the Statement of Reimbursable Cost should not be modified to refer to the middle paragraph.

Whatever the circumstances, as in the case of any engagement where an auditor expresses an opinion, the auditing work done should be sufficient to support the opinion.

Qualifications and Disclaimer of Opinion

Appropriate modification of the illustrative form will be required when the auditor finds it necessary to qualify his opinion or give a disclaimer of opinion.

There may be situations in which the auditor examining the costs claimed for reimbursement will not be able to formulate an opinion concerning such costs, or items included therein, either because restrictions were placed on the scope of his work by the intermediary or because the condition of the records was such as to prevent him from performing the work necessary in the circumstances. In these situations, in reporting on the costs claimed, the auditor should be guided by the discussion of qualified opinion and disclaimers of opinion in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

There also may be situations where the auditor will conclude that information shown is not presented fairly. These situations may concern instances where, for example, the auditor concludes that the statements of cost do not present certain information in conformity with accounting requirements of the Department of Health, Education, and Welfare, or where cost allocations are made improperly or information is inaccurate. In those situations the auditor should be guided by the discussion of qualified opinions and adverse opinions in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

Special Examinations

Intermediaries may seek the advice and assistance of auditors with respect to various accounting and auditing matters associated with medicare. This may include requests for special examinations, such as examinations of specific accounts of the extended care faciilty's Statmeents of Reimbursable Cost examined by other auditors. The form of report to be submitted in such cases should be designed to fit the individual situation and should set forth clearly the scope of the work performed and the results. The auditor should be careful in reporting on such situations that he does not give the impression of having assumed more responsibility than his special examination warrants. Generally, the provisions of Chapter 13 of SAP No. 33 dealing with special reports apply to such situations. In some cases "negative assurance" type of reports may be appropriate, provided the conditions described in paragraph 21 of Chapter 10 of SAP No. 33 are met.

HD 7102 U4 A3 no. 18



AUDIT PROGRAM FOR EXTENDED CARE FACILITIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

TITLE XVIII

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM 18 (1-68)

AUDIT PROGRAM
FOR EXTENDED CARE FACILITIES

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AUDIT PROGRAM FOR EXTENDED CARE FACILITIES UNDER THE HEALTH INSURANCE FOR THE AGED ACT

PART I—INTRODUCTION

A. *Authority*

This audit program has been prepared by the Department of Health, Education, and Welfare under the provisions of Sections 1816, 1842, 1861(v)(1), and 1871 of the Health Insurance for the Aged Act, Social Security Amendments of 1965, Public Law 89–97. The Act authorizes the Secretary of Health, Education, and Welfare to prescribe such regulations as may be necessary to carry out the administration of the insurance programs under Title XVIII.

B. *Responsibility*

The Secretary has the responsibility to establish regulations to be followed in the examination of financial and statistical records of providers being paid reasonable costs for services rendered to beneficiaries of the program. The Secretary has delegated to the Social Security Administration (SSA) the responsibility for policy formulation and the general management and operational aspects of the program including the prescribing of principles of reimbursement and related policies for use by providers in determining the reasonable cost of services furnished to beneficiaries. To facilitate the making of payments to providers for services furnished beneficiaries, the SSA has entered into agreements with private organizations to act as intermediaries for the purpose, among others, of determining the amount of reimbursement to be made to providers. Reimbursement is made directly by the intermediaries during the year on an estimated basis and final settlement is based on audited statements of providers' costs submitted on an annual basis.

C. *Purpose*

The examination is to be made in accordance with generally accepted auditing standards and must include, as a minimum, the auditing procedures prescribed by this audit program. The program is designed to provide the auditors with an outline of the minimum procedures to be considered during an examination of the accounting and statistical records of extended care facilities that are providers of services under the Health Insurance for the Aged Act. This program is also designed to aid in preventing the omission of important phases of the audit.

D. *Objectives*

The overall objectives of the audit of extended care facilities are to provide the intermediary with verified financial information as a basis for making a final determination of allowable costs; to assist the Secretary to discharge his responsibilities under the Health Insurance for the Aged Act; to aid in formulation of policy; and to provide verified financial and statistical information as a basis for decisions and reports to the Congress of the United States. More specifically, the objectives are:

1. To ascertain that the extended care facility is conforming to the intent of the Health Insurance for the Aged Act (Public Law 89–97) with respect to the payment regulations thereunder.

2. To review, analyze, test, and verify the extended care facility's financial and statistical books and records and to determine that only proper items of cost applicable to services furnished beneficiaries have been included in reimbursable cost. Where the above words are used in this program, the following generally accepted meanings are intended:

 a. Review—to study critically

 b. Analyze—to break into significant component parts in order to determine the nature of something

 c. Test—to examine representative items or samples for the purpose of arriving

at a conclusion as to the group from which the sample is selected

d. Verify—to establish accuracy

3. To verify on a selective basis that expenses attributable to the health insurance program have been accurately determined and are reasonable.

4. To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation are sufficient to properly develop valid and accurate statistical information.

E. Scope of Audit

The audit must be sufficiently comprehensive in scope to permit the expression in the audit report of an opinion as to whether, in all material respects, the reimbursement settlement schedule(s) of the ECF Statement of Reimbursable Cost present fairly the reimbursable costs of the extended care facility in conformity with the Principles of Reimbursement for Provider Costs issued by the Secretary. The auditor should make maximum utilization of extended care facility audits made by others, where available, insofar as such audits reasonably further the audit objectives of the program. As in any other examination, the auditor reporting on information contained in the reimbursement settlement schedule(s) should obtain sufficient evidential matter to form a reasonable basis for his opinion.

The effectiveness of internal controls, the nature of the providers' records, and the extent of audit work performed by the providers' auditor or other third-party auditors should be considered by the intermediary-appointed auditor in determining the scope of audit work to be performed. In selecting the procedures to be applied and the extent of testing to be done, the auditor should rely to the extent possible on the work of other auditors in the same manner that highly effective internal control procedures are utilized.

The audit program is not intended to place a maximum limitation on the scope or extent of the audit, nor is it intended as a substitute for the exercise of judgment by the auditor. The auditor should examine those areas that he considers necessary for the successful conclusion of the audit. Additional or more intensive examinations may be warranted whenever indicated by local circumstances.

The audit may be made by means of complete or partial analyses, tests, or sampling methods.

F. Reporting

An audit report must be prepared and submitted to the intermediary upon completion of the examination of each extended care facility. The auditor should comment on the facility's accounting and internal control systems insofar as they pertain to or affect the development of cost data under the prescribed principles of reimbursement. In addition, where the audit report contains a qualified opinion or a disclaimer of opinion, the comments should disclose the deficiencies which prevented the expression of an unqualified opinion and should offer suggestions for improvement. The auditor's certificate should, depending on the circumstances, conform to the forms included in Exhibit A, attached.

The auditor may elect to issue a separate report containing the auditor's comments, findings, and recommendations relating to matters that do not affect the rendition of an opinion on the reimbursement settlement schedule(s) of the facility's statement of reimbursable costs. When a separate report is prepared, it should be submitted to the intermediary together with the audit report on the statement of reimbursable costs, if possible, and in any event within 30 days after submission of the audit report. Where the auditor finds or observes that the extended care facility is not complying with directives issued by the intermediary or the SSA to a degree affecting the economical or effective operation of the program, these instances of noncompliance are to be disclosed and discussed in the comments.

Notwithstanding any provisions to the contrary, if the intermediary instructs the auditor to perform so limited an audit that the audit firm is not able to express an overall opinion as to the fairness of reasonable costs, then the auditor's report to the intermediary shall be limited to a summary of the audit work

actually performed and a listing of any matters noted in such examination which would reflect on the fairness of reasonable costs.

G. Non-Availability of Records

During the examination of the extended care facility's records, the auditor should limit himself to only those records that are essential to the full accomplishment of the audit. Whenever he requests the extended care facility to provide records for review and such requests are denied, he should make the circumstances the subject of a special note in his workpapers and report, and the intermediary should be consulted at once to determine whether the examination should be continued.

H. Disclosure of Contents of Audit Program and Results of Audit

The auditor is not to discuss or disclose the contents of the audit program or otherwise provide information with respects to specific audit approaches to anyone except authorized representatives of the intermediary and the Secretary. The scope of the audit and *overall* audit objectives and approaches should be discussed, however, with appropriate officials of the extended care facility during the initial conference at the start of the audit. The results of the audit are to be discussed with officials of the provider and intermediary during the audit and at the exit conference as appropriate under the circumstances (Part III–D). Audit working papers, programs, and reports, including permanent files and reviews of internal controls, pertaining to each provider audit will be retained by the auditor for at least three years after final payment for services under the contract for services and will be made available to representatives of the Secretary and the intermediary, at all reasonable times, for review and obtaining any necessary information.

I. Audit Guides

During the course of the examination, the auditor should look to the General Principles of Reimbursement 2-1 through 2-4 (Reg. Sec. 405.451–405.454)* which interpret the reimbursement provisions of Public Law 89–97. The legal limitations of reimbursement which are embodied in the "reasonable cost" concept and the requirements that only those costs attributable to beneficiaries of the program be reimbursed, serve as guidelines in determining the extent of allowable reimbursement. In addition to Public Law 89–97, the Health Insurance for the Aged Act, the following SSA publications will provide the auditor a general knowledge of the Health Insurance for the Aged program as it relates to extended care facilities:

Extended Care Facility Manual (HIM–12)
Principles of Reimbursement for Provider Costs (HIM–5)
Conditions of Participation for Extended Care Facilities (HIM–3)

The auditor shall refer questions of interpretations of the Social Security Act, as amended, or Principles of Reimbursement for Provider Costs to the intermediary. The auditor may accept the written reply of the intermediary to the questions as conclusive.

* This reference is to the stated principle of the Principles of Reimbursement for Provider Costs (HIM–5, Revised 1–67). Similar references will be made throughout the Audit Program.

AUDIT PROGRAM

PART II—GENERAL INSTRUCTIONS

A. Work at the Auditor's and/or Intermediary's Offices

1. Before contacting the extended care facility to be audited, the auditor should become familiar with Public Law 89–97, the regulations thereunder, and the approved principles of reimbursement. In addition, the auditor should discuss with the intermediary the possibility and need for reviewing the extended care facility file maintained at the intermediary's office to become familiar with the contents of pertinent documents that might be related to the extended care facility audit. Such documents could include:
 a. Contracts, if any, especially contracted services pertaining to medicare beneficiaries
 b. Financial statements including interim reimbursement payments
 c. Audit reports
 d. Statistical reports
 e. Correspondence
 f. Other pertinent information
2. The auditor should compare the current ECF statement of reimbursable cost with the prior one and note on worksheets for subsequent investigation any material differences of expenses shown on the two statements.
3. Prior to his arrival at the audit site, the intermediary's auditor should make arrangements with the extended care facility to make available when he arrives such records, books, documents, time studies, independent public accountant reports, auditor's adjustments, etc., which he deems necessary to the proper conduct of the audit.
4. The auditor should ascertain whether an audit has been completed by an independent public accountant covering the period of the statement of reimbursable cost and if so whether all necessary adjustments were made to the books and records.
5. The auditor should arrange to meet with the provider's auditor for the purpose of determining the extent of audit work done. He should discuss with the provider's auditor the scope of their work and their conclusions and refer to their audit program and working papers in order that he may select the procedures to be applied and the extent of testing to be done to form a reasonable basis for his opinion on information contained in the reimbursement settlement schedule(s) of the ECF statement of reimbursable cost.

B. Adjustments

1. During the examination of the records, etc., the auditor should promptly notify the responsible provider representative of proposed adjustments. This will give provider officials the opportunity to take such corrective or remedial action as may be necessary prior to the conclusion of the audit and also will expedite the "exit conference" as described in Part III–D.
 a. Any adjustment required as a result of the audit should be noted on an "Adjustment Report" prepared by the auditor and made part of the workpapers. The report should show the date, description of the adjustment, the dollar amount, and the extended care facility official contacted. It should also indicate whether the official agreed with the related change to the reimbursement settlement schedule(s).
 b. If adjustments are required which will materially affect the reimbursement settlement schedule(s) of the statement of reimbursable cost, the auditor should advise the intermediary so that consideration can be given to any possible effect on the current interim payment. If the responsible representative of the extended care facility does not agree with

the proposed changes, the intermediary should be advised so that he can discuss them with the provider's representative.

C. Audit Work at the Extended Care Facility

1. During preliminary discussion with officials of the extended care facility, the auditor should request that certain documents be placed at his disposal during the audit, including:

 a. Accounting books and records that are used in keeping account of the financial operations of the extended care facility.

 b. Statistical reports pertaining to the information furnished on the reimbursement settlement schedule(s) of the statement of reimbursable cost.

 c. Audit reports of the organization's own staff or others:

 (1) A copy of the latest audit report made by an independent public accountant should be requested for retention as a part of the audit workpapers.

 (2) A copy of the latest audit report prepared by any other third-party payer's auditors.

 d. Any or all types of reports that were prepared by the extended care facility in connection with the health insurance program or any other Federal program (where cost reimbursement is involved). For example, National Institute of Health grants for their Research Project Program, General Research Support Program, and General Clinical Research Center Program. (Note: These should be reviewed to determine whether the revenues and expenses compare generally with those included in the cost reporting forms for the health insurance program. Any conflict in handling of similar items, relative to reimbursement, between Federal programs should be brought to the attention of the intermediary and the Social Security Administration.)

 e. Schedules of charges for all patients at beginning and ending of reporting period. (Note: Schedule of charges during period should be reviewed to determine that such charges are effective for all patients and with no discrimination against any class of patients. To be acceptable, charges should be similar for all patients in the same type accommodations.)

 f. All workpapers supporting allocations, calculations, etc., on the reimbursement settlement schedule(s) of the statement of reimbursable cost.

 g. A trial balance of all funds, for all accounts included in the general ledger (to be retained in audit workpapers).

 h. All minutes of the directorate of the extended care facility and any of its committees.

2. The auditor should confer with the management of the extended care facility about unusual variations found in comparing the current statement of reimbursable cost with that of the preceding year. Replies should be noted on the worksheet recording the reasons for such changes.

3. If it is the auditor's first visit to the extended care facility, he should request a tour of the facility which will give him an opportunity to observe new equipment, additions, renovations, etc. If he had audited the facility prior to the current engagement, he should revisit those areas previously surveyed if the need for such visit is indicated by his discussion with provider officials.

4. Upon completion of preliminary work, the auditor should determine whether all records previously requested are available. The auditor should exercise the usual control of all records and documents made available exclusively for his use during the audit.

5. If the auditor is unable to obtain a trial balance under C–1–g above, prepare a trial balance of all funds, for all accounts included in the extended care facility's general ledger.

 a. Compare expense accounts on the trial

balance with those on the statement of reimbursable cost.

b. Reconcile (and evaluate differences between) total expenses on the trial balance with the total expenses on the statement of reimbursable cost.

c. Reconcile (and evaluate differences between) total expenses on the trial balance and statement of reimbursable cost with the audit report prepared by the extended care facility's outside auditors. (Review last year's reconciling items for comparability.)

6. Examination of expense accounts

a. If the auditor determines that any of the following audit procedures are not appropriate because of the limited amounts claimed in the provider's statement of reimbursable cost, or if he determines that the procedures have been adequately completed by the extended care facility's outside auditor and he is placing reliance thereon, he should include necessary explanations and/or cross-reference opposite the applicable procedures in the program. If applicable, the auditor should indicate in the workpapers the scope of the outside auditor's tests and should obtain copies of the outside auditor's workpapers where such documentation is needed to supplement or provide additional workpaper support.

During the examination of expenses, the auditor should note any transactions of material amount with provider-controlled or related organizations. The allowability of these expenses should be determined in accordance with Principle 1–10, Cost to Related Organizations (Reg. Sec. 405.427).

(1) The following accounts should be given special emphasis and, where necessary, analyzed to determine improper capital items and unallowable expenses (materiality should be considered when making judgment to analyze):

(a) Miscellaneous expense account or miscellaneous category (if any) included under other expense accounts

(b) Maintenance and repairs

(c) Operations of plant

(d) Professional fees (other than medical)

(e) Administration and general

(2) Limited tests should be made of the following accounts or expense categories to ascertain that charges thereto are reasonable and do not include capital items excludable from reimbursable cost:

(a) Nursing supplies and expenses

(b) Dietary supplies and expenses

(c) Pharmacy, laboratory, and x-ray supplies and expenses

(d) Supplies and expenses of special services

(3) Support salary expense (by departments) for the period by appropriate tests.

(4) Analyze interest expense for the period under review. Determine unallowable amount, if any, based on Principle 1–2, Interest Expense (Reg. Sec. 405.419).

(5) Review bad debts, if any, charged to the health insurance program and determine that collection effort was made. Such bad debts should be restricted to coinsurance amounts not collected, as reflected in Principle 1–3, Bad Debts, Charity, and Courtesy Allowances (Reg. Sec. 405.420).

(6) Review and analyze, where necessary, on a test basis, the fixed asset accounts. The auditor should satisfy himself as to the proper classification. Support major additions for the period and test the classification. Attention is directed to the cost basis to be used for the purchase of a facility as an on-going operation after July 1, 1966, as explained in Principle 1–1A, Allowance for Depreciation Based on Asset Costs

(Reg. Sec. 405.415). In the initial audit, some background and historical information should be included in workpapers regarding buildings, valuations, etc. The extended care facility's capitalization policy should be reviewed and noted in the workpapers.

(7) Review and test the computation of depreciation for the period, including the reasonableness of rates. Guidelines as to the reasonableness of rates may be obtained from publications of the American Hospital Association and the Internal Revenue Service. Determine that claimed depreciation expense meets the requirements of Principle 1–1, Depreciation (Reg. Secs. 405.415–405.418).

(8) Review and analyze, where necessary, any new expense account (new service, etc.) to determine the appropriateness and its applicability to reimbursable expenses.

(9) Rent expense should be analyzed and supported by reference to leases, correspondence, etc. The auditor should determine that expenses paid or incurred between related parties, as discussed in Principle 1–10, Cost to Related Organizations (Reg. Sec. 405.427), are in accordance with the proper application of that principle. Lease agreements (with option to buy) should be reviewed and, if substantial differences between normal depreciation and lease arrangements exist, these differences should be noted and commented upon. Sale and lease-back arrangements should be reviewed and adjusted where necessary in accordance with manual instructions.

(10) Costs and or expenses attributable to the following accounts (and similar items) are not to be included in patient costs; a review should be made to determine that such items have been correctly treated in accordance with health insurance program principles and regulations. In deciding upon the extent of the review, the materiality of the amounts involved should be considered. If the expenses (including applicable indirect costs) cannot be segregated and identified, then the income received should be used as a recovery:

(a) Telephone service (pay stations excluded)
(b) Radio and television service
(c) Laundry service for other than patients
(d) Linen service for other than patients
(e) Employee and guest meals
(f) Drugs and medical supplies sold to other than patients
(g) Private duty nurses
(h) Operation of gift shops and snack bars
(i) Personal expenses of owners
(j) Any other expenses not applicable to patient care

(11) Income related to the following accounts (and similar items) should be reflected in patient costs:

(a) Trade, quantity, time, and other discounts on purchases
(b) Rebates and refunds of expenses
(c) Grants, gifts, and income designated by the donor for specific expenses
(d) Commissions—vending machines
(e) Recovery of insured losses
(f) Rental of quarters to employees and others
(g) Sale of scrap, waste, etc.
(h) Payments received from specialists

7. Examination of income accounts

a. If the extended care facility has grants, these should be reviewed to determine if the principal and/or income affects the health insurance program reimbursable cost in any way.

b. Review other income accounts on the trial balance for possible recoveries of expenses. Analyze where necessary to determine that recoveries were included as such in the statement of reimbursable cost. (i.e., "Miscellaneous Income" if applicable).

c. Where applicable, test segregation of total charges to patients, departmentally, between health insurance program patients and total other patients and compare with percentages used in statement of reimbursable cost for application of RCCAC (ratio of charges to charges applied to cost). If the Intermediary accumulates charges to health insurance program patients, this accumulation should be reconciled to amounts shown on the provider's statement of reimbursable cost.

d. Tests should be made to determine that the schedule of charges applied to health insurance program patients and all other patients are consistent and comparable. Compare on a test basis with a copy of rates shown in the schedules obtained in Part II–C–1, step e. Inquiry should be made as to whether the extended care facility has any special charging arrangements (other than the regular schedules) with special groups such as group practice prepayment plans which would affect the RCCAC application.

e. Prepare schedule of selected admissions to the extended care facility, ascertain respective dates of discharge, and substantiate charges and credits or allowances for periods of occupancy. This test should include health insurance program patients and other patients.

8. Additional audit activity

a. Review any other accounts on the trial balance where the content is not known and which may affect the statement of reimbursable cost, such as capital fund account, retained earnings, surplus, etc. In some instances the year end audit report may show this information.

b. Review and analyze, if necessary, any other balance sheet account which may affect the final determination of reimbursable costs; i.e., "inventories," "prepaid expenses," and "accrued expenses."

c. Determine the reason for any unusual and material fluctuation in expense or income accounts and balance sheet accounts for this period as compared with the prior period; analyze where necessary. Explain the differences in the workpapers. This refers to those accounts whose fluctuations were not examined during review of the statement of reimbursable cost.

d. Determine that any recommendations or adjustments included in the prior cost audit that affected this period were handled correctly.

e. Test the computation of the settlement, included in the reimbursement settlement schedule(s) of the statements of reimbursable cost between the provider and the Intermediary. This will include comparisons of the "charges" portion of the settlement calculation with the provider's books and records.

9. Test of statistical information

a. Review the extended care facility's method of gathering and reporting the statistical information shown on its statement of reimbursable cost. Limited tests of the statistical data should be made.

b. Include in the workpapers a brief description of the method followed by the provider and a conclusion as to the adequacy of the method and the reliability of the statistical information shown on the statement of reimbursable cost.

c. Where in-patient days are involved in the settlement computations, they might be tested by verifying the daily listings on the monthly summaries to the daily census sheets and test some footing totals of the daily census sheets. Test add the monthly summaries and compare with the amount shown on the statement of reimbursable cost. Reference should be made to a limited number of medical histories and traced through to the daily

census listings during the period. Conversely, some tests should be made from daily census listings to medical histories. By similar limited tests determine that accumulation of patient days for health insurance program patients is reasonably correct. If the Intermediary accumulates program patient days, this accumulation should be reconciled to that by the provider.

10. Miscellaneous

a. If the extended care facility includes amounts for voluntary services by individuals, including services of members of religious orders, obtain a schedule showing salary and other allowances by occupation, and the department to which the annual amount is charged. Review this schedule to determine that amounts allowed do not exceed those amounts paid to others for similar services. Determine that maintenance costs for religious personnel are not included in the allowance. Retain the schedule in the workpapers. The requirements of Principle 1–7, Value of Services of Nonpaid Workers (Reg. Sec. 405.424), should be applied in these cases.

b. The amounts and bases of allocation of expenses to and from affiliated hospitals, universities, nursing homes, public health departments, etc., (which are connected with the extended care facility's operations) should be carefully reviewed.

c. Review contracts with and costs applicable to facility-based physicians and other professional people on the payroll to determine reimbursable amounts under Public Law 89–97 and the regulations thereunder. (Note: physicians' services must be rendered in the capacity of consultant or administrator).

d. Expenses relative to approved educational activities as defined in Principle 1–4, Cost of Educational Activities (Reg. Sec. 405.421), should be reviewed and the amount subject to reimbursement under Public Law 89–97 determined.

e. Grants, gifts, and income from endowments should be tested to determine applicability of Principle 1–6, Grants, Gifts, and Income From Endowments (Reg. Sec. 405.423), and any necessary adjustments made to the cost schedules.

f. Determine that the amount of current financing, if any, under the health insurance program shown on the provider's records agrees with amount shown by the intermediary.

g. Review income and expense accounts in other funds (i.e., endowment, plant, and temporary) to determine if any amounts might affect the statement of reimbursable cost. Analyze where necessary.

h. Determine that the cost claimed under Principle 1–11, Allowance in Lieu of Specific Recognition of Other Costs (Reg. Sec. 405.428), is properly computed.

11. Profit Oriented Entities

a. If the extended care facility is a proprietary institution, the following additional audit procedures should be considered:

(1) Review insurance expense and other expense accounts to determine whether personal and other unallowable items are included. Special attention should be given to Principles 1–9, Compensation of Owners (Reg. Sec. 405.426), and 1–10, Cost to Related Organizations (Reg. Sec. 405.427). If, in the auditor's opinion, payments to owners appear excessive, the information should be reported to the Intermediary.

(2) Paid or accrued income taxes are not allowable items of reimbursable costs.

(3) Determine that the cost claimed under Principle 1–12, Return on Equity Capital of Proprietary Providers (Reg. Sec. 405.429), is properly computed.

PART III—CONCLUSION

A. Review of Work Papers and Schedules

At the conclusion of the examination, the auditor should possess all of the data in his workpapers necessary to support and explain the list of changes included on the "Adjustment Report."

Before leaving the extended care facility, the auditor should review the workpapers to assure that all data, information, schedules, and necessary notes are included to adequately support the audit and the audit report.

The audit program, or a separate audit check list, should be included in the forepart of the audit working papers. Each audit step, or segment of related steps, should be initialed to indicate completion of the audit work required and cross referenced to the supporting audit working papers. At the conclusion of the examination, the audit program, or audit check list, should be reviewed to determine that all functions were performed or satisfactory explanation was recorded for those omitted.

B. Return of Basic Documents

The auditor should be certain that at the conclusion of the audit he has returned all of the extended care facility's files, books, and documents in the same condition as they were presented to him.

C. Audit Results

All of the proposed adjustments to the reimbursement settlement schedule(s) of the statement of reimbursable cost must be included on the "Adjustment Report" which should be prepared in triplicate. The auditor should have the extended care facility calculate the final net change and prepare the revised reimbursement settlement schedule(s) of the statement of reimbursable cost upon which the auditor will render his opinion. The auditor will make a complete mathematical verification of the revised reimbursement settlement schedule(s) and supporting data.

D. Exit Conference

An exit conference should be arranged by the auditor with the administrator and/or financial executive of the extended care facility. All changes listed on the "Adjustment Report" should be discussed. The extended care facility's representative should be requested to sign two copies of the "Adjustment Report" indicating agreement to the changes in the cost report. The third copy of the "Adjustment Report" should be given to the extended care facility. One signed copy of the report should be retained by the auditor in his workpapers and one copy should be sent to the intermediary with a corrected copy of the statement of reimbusable cost. If the extended care facility's executives and the auditor cannot agree to all the proposed changes, then the intermediary should be requested to participate in the conference to resolve the disagreement.

E. Summary of Notes on Audit

A "Summary of Notes on Audit" should be included in the workpapers listing any unusual facts concerning this audit and any relevant information that may assist the auditor performing the next audit.

SUGGESTED FORMS OF CERTIFICATION

The form of opinion shown below is intended to be illustrative of the opinion that independent auditors should give where they have examined the extended care facility's Statement of Reimbursable Costs. The illustrative forms of opinion, together with the accompanying comments, have been restated from a memorandum prepared by the Subcommittee on Compliance Reports of the Committee on Auditing Procedure of the American Institute of Certified Public Accountants relating to reports on examinations of hospital statements of reimbursable costs under medicare. Changes have been made only where appropriate to make the language applicable to the examination of extended care facility costs.

Illustrative Form of Report

We have examined the information shown on the reimbursement settlement schedule(s) of the Extended Care Facility Statement of Reimbursable Cost of the _____ for the year ended _____. Our examination of this information was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the Audit Program for Extended Care Facilities published by the Department of Health, Education, and Welfare, as we considered necessary in the circumstances.

In our opinion, the reimbursement settlement schedule(s) of the accompanying Extended Care Facility Statement of Reimbursable Cost present fairly in all material respects the information shown therein, in conformity with the Principles of Reimbursement for Provider Costs published by the Secretary of Health, Education, and Welfare applied as described in the notes to the statement.

Signature

Date

The foregoing form of opinion is appropriate for use by the provider's auditor as well as by the intermediary-appointed auditors who may or may not have examined the provider's financial statements. In circumstances where the provider's unaudited financial statements, in complete or partial form, are included as part of the statement of reimbursable cost, such financial statements should be marked as "unaudited" and a middle paragraph should be added to the report expressing a disclaimer of opinion on the financial statements. Where the financial statements submitted have been examined by either (a) the auditor rendering the report on the reimbursement settlement schedule(s) of the Statement of Reimbursable Cost or (b) the provider's auditor a middle paragraph may be added as follows:

As to situation (a)

We have examined the financial statements of _____ for the year ended _____ and have rendered our report thereon under date of _____.

As to situation (b)

> We have not examined the financial statements of _____ for the year ended _____, and accordingly we do not express an opinion on them. Such statements were examined by other public accountants who have reported on them under date of _____.

Since inclusion of the middle paragraph is intended solely to furnish information about any examinations that may have been made of the financial statements included in the statement of reimbursable cost and not to indicate a sharing of responsibility, the opinion expressed as to the reimbursement settlement schedule(s) of the Statement of Reimbursable Cost should not be modified to refer to the middle paragraph.

Whatever the circumstances, as in the case of any engagement where an auditor expresses an opinion, the auditing work done should be sufficient to support the opinion.

Qualifications and Disclaimer of Opinion

Appropriate modification of the illustrative form will be required when the auditor finds it necessary to qualify his opinion or give a disclaimer of opinion.

There may be situations in which the auditor examining the costs claimed for reimbursement will not be able to formulate an opinion concerning such costs, or items included therein, either because restrictions were placed on the scope of his work by the intermediary or because the condition of the records was such as to prevent him from performing the work necessary in the circumstances. In these situations, in reporting on the costs claimed, the auditor should be guided by the discussion of qualified opinion and disclaimers of opinion in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

There also may be situations where the auditor will conclude that information shown is not presented fairly. These situations may concern instances where, for example, the auditor concludes that the statements of cost do not present certain information in conformity with accounting requirements of the Department of Health, Education, and Welfare, or where cost allocations are made improperly or information is inaccurate. In those situations the auditor should be guided by the discussion of qualified opinions and adverse opinions in Chapter 10 of AICPA Statement on Auditing Procedure No. 33.

Special Examinations

Intermediaries may seek the advice and assistance of auditors with respect to various accounting and auditing matters associated with medicare. This may include requests for special examinations, such as examinations of specific accounts of the extended care faciilty's Statmeents of Reimbursable Cost examined by other auditors. The form of report to be submitted in such cases should be designed to fit the individual situation and should set forth clearly the scope of the work performed and the results. The auditor should be careful in reporting on such situations that he does not give the impression of having assumed more responsibility than his special examination warrants. Generally, the provisions of Chapter 13 of SAP No. 33 dealing with special reports apply to such situations. In some cases "negative assurance" type of reports may be appropriate, provided the conditions described in paragraph 21 of Chapter 10 of SAP No. 33 are met.

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